

AMENDED IN ASSEMBLY JUNE 10, 2014

AMENDED IN SENATE MARCH 17, 2014

**SENATE BILL**

**No. 959**

---

**Introduced by Senator Hernandez**

February 6, 2014

---

An act to amend Section 100503 of the Government Code, to amend Sections 1357.503, 1366.6, 1367.005, 1367.006, 1374.21, 1385.03, 1385.06, 1385.07, 1385.11, 1389.25, and 1399.849 of the Health and Safety Code, and to amend Sections 10112.27, 10112.28, 10112.3, 10113.9, 10181.3, 10181.6, 10181.7, 10181.11, 10199.1, 10753.05, and 10965.3 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 959, as amended, Hernandez. Health care coverage.

~~Existing~~

(1) *Existing* federal law, the federal Patient Protection and Affordable Care Act (PPACA), enacts various health care coverage market reforms that take effect January 1, 2014. Among other things, PPACA requires each state to, by January 1, 2014, establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers. PPACA requires a health insurance issuer to consider all enrollees in its individual market plans to be part of a single risk pool and to consider all enrollees in its small group market plans to be part of a single risk pool. PPACA also requires an issuer to establish an index rate for each of those markets based on the total combined claim costs for providing essential health benefits within the single risk pool for that market and authorizes the issuer to vary premium rates from the index rate based only on specified factors. PPACA requires that the index rate be adjusted based on

Exchange user fees and expected payments and charges under certain risk adjustment and reinsurance programs.

Existing law establishes the California Health Benefit Exchange within state government for the purpose of facilitating the purchase of qualified health plans through the Exchange by qualified individuals and small employers. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan and a health insurer to consider as a single risk pool the claims experience of all enrollees and insureds in its nongrandfathered small employer ~~plans, whether offered as health care service plan contracts or health insurance policies, plans~~ and to also consider as a single risk pool the claims experience of all enrollees and insureds in its nongrandfathered individual market ~~plans, whether offered as health care service plan contracts or health insurance policies, plans~~. Existing law requires a plan or insurer to establish an index rate for those markets, as specified, and authorizes the plan or insurer to vary premium rates from the index rate based only on specified factors. Existing law requires that the index rate be adjusted based on expected payments and charges under the risk adjustment and reinsurance programs specified under PPACA.

~~This bill would require that both the enrollees of nongrandfathered individual health benefit plans issued by a health care service plan and the insureds of nongrandfathered individual health benefit plans issued by a health insurer that is a corporate affiliate, subsidiary, or parent of the plan be part of a single risk pool and would make parallel changes with respect to the small group market. The bill would require that the index rate also be adjusted based on Exchange user fees, as specified under PPACA.~~

PPACA requires a health insurance issuer offering coverage in the individual or small group market to ensure that the coverage includes the essential health benefits package and defines this package to mean coverage that, among other requirements, provides the platinum, gold, silver, or bronze level of coverage or, in the individual market, provides catastrophic coverage to specified individuals. Existing law requires health care service plans and health insurers participating in the Exchange to fairly and affirmatively offer, market, and sell in the Exchange at least one product in each of these 5 levels of coverage.

Existing law requires a health care service plan or health insurer that does not participate in the Exchange to offer at least one standardized product designated by the Exchange in each of the platinum, gold, silver, and ~~bronzed~~ *bronze* levels of coverage.

This bill would specify that health care service plans and health insurers participating in the small group market of the Exchange are only required to fairly and affirmatively offer, market, and sell in that market the platinum, gold, silver, and bronze levels of coverage. The bill would also specify that the requirement for plans or insurers not participating in the Exchange to offer at least one standardized product designated by the Exchange in each of those levels of coverage only applies to the individual and small group markets.

~~Existing~~

(2) *Existing* law prohibits a health care service plan or a health insurer offering coverage in the individual market from changing the premium rate or coverage without providing specified notice to the subscriber or policyholder at least 60 days prior to the contract or policy renewal date.

The bill would require that the notice be sent on the earlier of 60 days prior to the renewal date or 15 days prior to the start of the annual enrollment period applicable to the contract or policy.

Existing law requires a plan or insurer that declines to offer coverage or denies enrollment for an individual or his or her dependents applying for individual coverage or that offers individual or small group coverage at a rate that is higher than the standard rate to provide the applicant with the reason for the decision in writing. *Existing law also requires the plan or insurer to inform the applicant about specified high risk pools, including the California Major Risk Medical Insurance Program, and specifies that this requirement does not apply when a plan or insurer rejects an applicant for Medicare supplement coverage.*

This bill would delete ~~those requirements~~; *the requirement that the plan or insurer provide the applicant with the reason for the denial or higher than standard rate. The bill would require a plan or insurer to inform specified applicants for a grandfathered health plan who are denied or charged a higher than standard rate, and applicants for Medicare supplement coverage who are denied due to a specified condition, about the California Major Risk Medical Insurance Program and the Exchange, as specified.*

~~Existing~~

(3) *Existing* law requires a health care service plan or health insurer in the individual or small group market to file rate information with the Department of Managed Health Care or the Department of Insurance, as applicable, at least 60 days prior to implementing a rate change and requires the filing to be concurrent with the notice sent to subscribers prior to increasing premium rates. Existing law requires that the rate filing include specified information regarding the proposed rate increase and the plan's overall annual medical trend factor assumptions in each rate filing for all benefits and by aggregate benefit category. Existing law authorizes the plan to provide aggregated additional data that demonstrates year-to-year cost increases in specific benefit categories in major geographic regions of the state to be defined by the department to include no more than 9 regions.

This bill would eliminate the requirement that the rate filing be concurrent with the notice sent to subscribers prior to increasing premium rates. The bill would also require that a rate filing include specified information regarding a plan or insurer's proposed rate change, rather than rate increase, and would require that the geographic regions correspond with those regions used by the plan to establish premium rates.

The bill would make other related, conforming, and technical changes.

**Because**

(4) *Because* a willful violation of the bill's requirements with respect to health care service plans would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.  
State-mandated local program: yes.

*The people of the State of California do enact as follows:*

- 1 SECTION 1. Section 100503 of the Government Code, as
- 2 amended by Section 4 of Chapter 5 of the First Extraordinary
- 3 Session of the Statutes of 2013, is amended to read:

100503. In addition to meeting the minimum requirements of Section 1311 of the federal act, the board shall do all of the following:

(a) Determine the criteria and process for eligibility, enrollment, and disenrollment of enrollees and potential enrollees in the Exchange and coordinate that process with the state and local government entities administering other health care coverage programs, including the State Department of Health Care Services, the Managed Risk Medical Insurance Board, and California counties, in order to ensure consistent eligibility and enrollment processes and seamless transitions between coverage.

(b) Develop processes to coordinate with the county entities that administer eligibility for the Medi-Cal program and the entity that determines eligibility for the Healthy Families Program, including, but not limited to, processes for case transfer, referral, and enrollment in the Exchange of individuals applying for assistance to those entities, if allowed or required by federal law.

(c) Determine the minimum requirements a carrier must meet to be considered for participation in the Exchange, and the standards and criteria for selecting qualified health plans to be offered through the Exchange that are in the best interests of qualified individuals and qualified small employers. The board shall consistently and uniformly apply these requirements, standards, and criteria to all carriers. In the course of selectively contracting for health care coverage offered to qualified individuals and qualified small employers through the Exchange, the board shall seek to contract with carriers so as to provide health care coverage choices that offer the optimal combination of choice, value, quality, and service.

(d) Provide, in each region of the state, a choice of qualified health plans at each of the five levels of coverage contained in subsections (d) and (e) of Section 1302 of the federal act, subject to subdivision (e) of this section, paragraph (2) of subdivision (d) of Section 1366.6 of the Health and Safety Code, and paragraph (2) of subdivision (d) of Section 10112.3 of the Insurance Code.

(e) Require, as a condition of participation in the individual market of the Exchange, carriers to fairly and affirmatively offer, market, and sell in the individual market of the Exchange at least one product within each of the five levels of coverage contained in subsections (d) and (e) of Section 1302 of the federal act and

1 require, as a condition of participation in the SHOP Program,  
2 carriers to fairly and affirmatively offer, market, and sell in the  
3 SHOP Program at least one product within each of the four levels  
4 of coverage contained in subsection (d) of Section 1302 of the  
5 federal act. The board may require carriers to offer additional  
6 products within each of those levels of coverage. This subdivision  
7 shall not apply to a carrier that solely offers supplemental coverage  
8 in the Exchange under paragraph (10) of subdivision (a) of Section  
9 100504.

10 (f) (1) Except as otherwise provided in this section and Section  
11 100504.5, require, as a condition of participation in the Exchange,  
12 carriers that sell any products outside the Exchange to do both of  
13 the following:

14 (A) Fairly and affirmatively offer, market, and sell all products  
15 made available to individuals in the Exchange to individuals  
16 purchasing coverage outside the Exchange.

17 (B) Fairly and affirmatively offer, market, and sell all products  
18 made available to small employers in the Exchange to small  
19 employers purchasing coverage outside the Exchange.

20 (2) For purposes of this subdivision, “product” does not include  
21 contracts entered into pursuant to Part 6.2 (commencing with  
22 Section 12693) of Division 2 of the Insurance Code between the  
23 Managed Risk Medical Insurance Board and carriers for enrolled  
24 Healthy Families beneficiaries or contracts entered into pursuant  
25 to Chapter 7 (commencing with Section 14000) of, or Chapter 8  
26 (commencing with Section 14200) of, Part 3 of Division 9 of the  
27 Welfare and Institutions Code between the State Department of  
28 Health Care Services and carriers for enrolled Medi-Cal  
29 beneficiaries. “Product” also does not include a bridge plan product  
30 offered pursuant to Section 100504.5.

31 (3) Except as required by Section 1301(a)(1)(C)(ii) of the federal  
32 act, a carrier offering a bridge plan product in the Exchange may  
33 limit the products it offers in the Exchange solely to a bridge plan  
34 product contract.

35 (g) Determine when an enrollee’s coverage commences and the  
36 extent and scope of coverage.

37 (h) Provide for the processing of applications and the enrollment  
38 and disenrollment of enrollees.

39 (i) Determine and approve cost-sharing provisions for qualified  
40 health plans.

1 (j) Establish uniform billing and payment policies for qualified  
2 health plans offered in the Exchange to ensure consistent  
3 enrollment and disenrollment activities for individuals enrolled in  
4 the Exchange.

5 (k) Undertake activities necessary to market and publicize the  
6 availability of health care coverage and federal subsidies through  
7 the Exchange. The board shall also undertake outreach and  
8 enrollment activities that seek to assist enrollees and potential  
9 enrollees with enrolling and reenrolling in the Exchange in the  
10 least burdensome manner, including populations that may  
11 experience barriers to enrollment, such as the disabled and those  
12 with limited English language proficiency.

13 (l) Select and set performance standards and compensation for  
14 navigators selected under subdivision (l) of Section 100502.

15 (m) Employ necessary staff.

16 (1) The board shall hire a chief fiscal officer, a chief operations  
17 officer, a director for the SHOP Exchange, a director of Health  
18 Plan Contracting, a chief technology and information officer, a  
19 general counsel, and other key executive positions, as determined  
20 by the board, who shall be exempt from civil service.

21 (2) (A) The board shall set the salaries for the exempt positions  
22 described in paragraph (1) and subdivision (i) of Section 100500  
23 in amounts that are reasonably necessary to attract and retain  
24 individuals of superior qualifications. The salaries shall be  
25 published by the board in the board's annual budget. The board's  
26 annual budget shall be posted on the Internet Web site of the  
27 Exchange. To determine the compensation for these positions, the  
28 board shall cause to be conducted, through the use of independent  
29 outside advisors, salary surveys of both of the following:

30 (i) Other state and federal health insurance exchanges that are  
31 most comparable to the Exchange.

32 (ii) Other relevant labor pools.

33 (B) The salaries established by the board under subparagraph  
34 (A) shall not exceed the highest comparable salary for a position  
35 of that type, as determined by the surveys conducted pursuant to  
36 subparagraph (A).

37 (C) The Department of Human Resources shall review the  
38 methodology used in the surveys conducted pursuant to  
39 subparagraph (A).

(3) The positions described in paragraph (1) and subdivision (i) of Section 100500 shall not be subject to otherwise applicable provisions of the Government Code or the Public Contract Code and, for those purposes, the Exchange shall not be considered a state agency or public entity.

(n) Assess a charge on the qualified health plans offered by carriers that is reasonable and necessary to support the development, operations, and prudent cash management of the Exchange. This charge shall not affect the requirement under Section 1301 of the federal act that carriers charge the same premium rate for each qualified health plan whether offered inside or outside the Exchange.

(o) Authorize expenditures, as necessary, from the California Health Trust Fund to pay program expenses to administer the Exchange.

(p) Keep an accurate accounting of all activities, receipts, and expenditures, and annually submit to the United States Secretary of Health and Human Services a report concerning that accounting. Commencing January 1, 2016, the board shall conduct an annual audit.

(q) (1) Annually prepare a written report on the implementation and performance of the Exchange functions during the preceding fiscal year, including, at a minimum, the manner in which funds were expended and the progress toward, and the achievement of, the requirements of this title. The report shall also include data provided by health care service plans and health insurers offering bridge plan products regarding the extent of health care provider and health facility overlap in their Medi-Cal networks as compared to the health care provider and health facility networks contracting with the plan or insurer in their bridge plan contracts. This report shall be transmitted to the Legislature and the Governor and shall be made available to the public on the Internet Web site of the Exchange. A report made to the Legislature pursuant to this subdivision shall be submitted pursuant to Section 9795.

(2) The Exchange shall prepare, or contract for the preparation of, an evaluation of the bridge plan program using the first three years of experience with the program. The evaluation shall be provided to the health policy and fiscal committees of the Legislature in the fourth year following federal approval of the



1 bridge plan option. The evaluation shall include, but not be limited  
2 to, all of the following:

3 (A) The number of individuals eligible to participate in the  
4 bridge plan program each year by category of eligibility.

5 (B) The number of eligible individuals who elect a bridge plan  
6 option each year by category of eligibility.

7 (C) The average length of time, by region and statewide, that  
8 individuals remain in the bridge plan option each year by category  
9 of eligibility.

10 (D) The regions of the state with a bridge plan option, and the  
11 carriers in each region that offer a bridge plan, by year.

12 (E) The premium difference each year, by region, between the  
13 bridge plan and the first and second lowest cost plan for individuals  
14 in the Exchange who are not eligible for the bridge plan.

15 (F) The effect of the bridge plan on the premium subsidy amount  
16 for bridge plan eligible individuals each year by each region.

17 (G) Based on a survey of individuals enrolled in the bridge plan:

18 (i) Whether individuals enrolling in the bridge plan product are  
19 able to keep their existing health care providers.

20 (ii) Whether individuals would want to retain their bridge plan  
21 product, buy a different Exchange product, or decline to purchase  
22 health insurance if there was no bridge plan product available. The  
23 Exchange may include questions designed to elicit the information  
24 in this subparagraph as part of an existing survey of individuals  
25 receiving coverage in the Exchange.

26 (3) In addition to the evaluation required by paragraph (2), the  
27 Exchange shall post the items in subparagraphs (A) to (F),  
28 inclusive, on its Internet Web site each year.

29 (4) In addition to the report described in paragraph (1), the board  
30 shall be responsive to requests for additional information from the  
31 Legislature, including providing testimony and commenting on  
32 proposed state legislation or policy issues. The Legislature finds  
33 and declares that activities including, but not limited to, responding  
34 to legislative or executive inquiries, tracking and commenting on  
35 legislation and regulatory activities, and preparing reports on the  
36 implementation of this title and the performance of the Exchange,  
37 are necessary state requirements and are distinct from the  
38 promotion of legislative or regulatory modifications referred to in  
39 subdivision (d) of Section 100520.

1 (r) Maintain enrollment and expenditures to ensure that  
2 expenditures do not exceed the amount of revenue in the fund, and  
3 if sufficient revenue is not available to pay estimated expenditures,  
4 institute appropriate measures to ensure fiscal solvency.

5 (s) Exercise all powers reasonably necessary to carry out and  
6 comply with the duties, responsibilities, and requirements of this  
7 act and the federal act.

8 (t) Consult with stakeholders relevant to carrying out the  
9 activities under this title, including, but not limited to, all of the  
10 following:

11 (1) Health care consumers who are enrolled in health plans.

12 (2) Individuals and entities with experience in facilitating  
13 enrollment in health plans.

14 (3) Representatives of small businesses and self-employed  
15 individuals.

16 (4) The State Medi-Cal Director.

17 (5) Advocates for enrolling hard-to-reach populations.

18 (u) Facilitate the purchase of qualified health plans in the  
19 Exchange by qualified individuals and qualified small employers  
20 no later than January 1, 2014.

21 (v) Report, or contract with an independent entity to report, to  
22 the Legislature by December 1, 2018, on whether to adopt the  
23 option in Section 1312(c)(3) of the federal act to merge the  
24 individual and small employer markets. In its report, the board  
25 shall provide information, based on at least two years of data from  
26 the Exchange, on the potential impact on rates paid by individuals  
27 and by small employers in a merged individual and small employer  
28 market, as compared to the rates paid by individuals and small  
29 employers if a separate individual and small employer market is  
30 maintained. A report made pursuant to this subdivision shall be  
31 submitted pursuant to Section 9795.

32 (w) With respect to the SHOP Program, collect premiums and  
33 administer all other necessary and related tasks, including, but not  
34 limited to, enrollment and plan payment, in order to make the  
35 offering of employee plan choice as simple as possible for qualified  
36 small employers.

37 (x) Require carriers participating in the Exchange to immediately  
38 notify the Exchange, under the terms and conditions established  
39 by the board when an individual is or will be enrolled in or  
40 disenrolled from any qualified health plan offered by the carrier.

(y) Ensure that the Exchange provides oral interpretation services in any language for individuals seeking coverage through the Exchange and makes available a toll-free telephone number for the hearing and speech impaired. The board shall ensure that written information made available by the Exchange is presented in a plainly worded, easily understandable format and made available in prevalent languages.

(z) This section shall become inoperative on the October 1 that is five years after the date that federal approval of the bridge plan option occurs, and, as of the second January 1 thereafter, is repealed, unless a later enacted statute that is enacted before that date deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 2. Section 100503 of the Government Code, as added by Section 5 of Chapter 5 of the First Extraordinary Session of the Statutes of 2013, is amended to read:

100503. In addition to meeting the minimum requirements of Section 1311 of the federal act, the board shall do all of the following:

(a) Determine the criteria and process for eligibility, enrollment, and disenrollment of enrollees and potential enrollees in the Exchange and coordinate that process with the state and local government entities administering other health care coverage programs, including the State Department of Health Care Services, the Managed Risk Medical Insurance Board, and California counties, in order to ensure consistent eligibility and enrollment processes and seamless transitions between coverage.

(b) Develop processes to coordinate with the county entities that administer eligibility for the Medi-Cal program and the entity that determines eligibility for the Healthy Families Program, including, but not limited to, processes for case transfer, referral, and enrollment in the Exchange of individuals applying for assistance to those entities, if allowed or required by federal law.

(c) Determine the minimum requirements a carrier must meet to be considered for participation in the Exchange, and the standards and criteria for selecting qualified health plans to be offered through the Exchange that are in the best interests of qualified individuals and qualified small employers. The board shall consistently and uniformly apply these requirements, standards, and criteria to all carriers. In the course of selectively

1 contracting for health care coverage offered to qualified individuals  
2 and qualified small employers through the Exchange, the board  
3 shall seek to contract with carriers so as to provide health care  
4 coverage choices that offer the optimal combination of choice,  
5 value, quality, and service.

6 (d) Provide, in each region of the state, a choice of qualified  
7 health plans at each of the five levels of coverage contained in  
8 subsections (d) and (e) of Section 1302 of the federal act, subject  
9 to subdivision (e) of this section, paragraph (2) of subdivision (d)  
10 of Section 1366.6 of the Health and Safety Code and paragraph  
11 (2) of subdivision (d) of Section 10112.3 of the Insurance Code.

12 (e) Require, as a condition of participation in the Exchange,  
13 carriers to fairly and affirmatively offer, market, and sell in the  
14 Exchange at least one product within each of the five levels of  
15 coverage contained in subsections (d) and (e) of Section 1302 of  
16 the federal act and require, as a condition of participation in the  
17 SHOP Program, carriers to fairly and affirmatively offer, market,  
18 and sell in the SHOP Program at least one product within each of  
19 the four levels of coverage contained in subsection (d) of Section  
20 1302 of the federal act. The board may require carriers to offer  
21 additional products within each of those levels of coverage. This  
22 subdivision shall not apply to a carrier that solely offers  
23 supplemental coverage in the Exchange under paragraph (10) of  
24 subdivision (a) of Section 100504.

25 (f) (1) Require, as a condition of participation in the Exchange,  
26 carriers that sell any products outside the Exchange to do both of  
27 the following:

28 (A) Fairly and affirmatively offer, market, and sell all products  
29 made available to individuals in the Exchange to individuals  
30 purchasing coverage outside the Exchange.

31 (B) Fairly and affirmatively offer, market, and sell all products  
32 made available to small employers in the Exchange to small  
33 employers purchasing coverage outside the Exchange.

34 (2) For purposes of this subdivision, “product” does not include  
35 contracts entered into pursuant to Part 6.2 (commencing with  
36 Section 12693) of Division 2 of the Insurance Code between the  
37 Managed Risk Medical Insurance Board and carriers for enrolled  
38 Healthy Families beneficiaries or contracts entered into pursuant  
39 to Chapter 7 (commencing with Section 14000) of, or Chapter 8  
40 (commencing with Section 14200) of, Part 3 of Division 9 of the

1 Welfare and Institutions Code between the State Department of  
2 Health Care Services and carriers for enrolled Medi-Cal  
3 beneficiaries.

4 (g) Determine when an enrollee's coverage commences and the  
5 extent and scope of coverage.

6 (h) Provide for the processing of applications and the enrollment  
7 and disenrollment of enrollees.

8 (i) Determine and approve cost-sharing provisions for qualified  
9 health plans.

10 (j) Establish uniform billing and payment policies for qualified  
11 health plans offered in the Exchange to ensure consistent  
12 enrollment and disenrollment activities for individuals enrolled in  
13 the Exchange.

14 (k) Undertake activities necessary to market and publicize the  
15 availability of health care coverage and federal subsidies through  
16 the Exchange. The board shall also undertake outreach and  
17 enrollment activities that seek to assist enrollees and potential  
18 enrollees with enrolling and reenrolling in the Exchange in the  
19 least burdensome manner, including populations that may  
20 experience barriers to enrollment, such as the disabled and those  
21 with limited English language proficiency.

22 (l) Select and set performance standards and compensation for  
23 navigators selected under subdivision (l) of Section 100502.

24 (m) Employ necessary staff.

25 (1) The board shall hire a chief fiscal officer, a chief operations  
26 officer, a director for the SHOP Exchange, a director of Health  
27 Plan Contracting, a chief technology and information officer, a  
28 general counsel, and other key executive positions, as determined  
29 by the board, who shall be exempt from civil service.

30 (2) (A) The board shall set the salaries for the exempt positions  
31 described in paragraph (1) and subdivision (i) of Section 100500  
32 in amounts that are reasonably necessary to attract and retain  
33 individuals of superior qualifications. The salaries shall be  
34 published by the board in the board's annual budget. The board's  
35 annual budget shall be posted on the Internet Web site of the  
36 Exchange. To determine the compensation for these positions, the  
37 board shall cause to be conducted, through the use of independent  
38 outside advisors, salary surveys of both of the following:

39 (i) Other state and federal health insurance exchanges that are  
40 most comparable to the Exchange.

1 (ii) Other relevant labor pools.

2 (B) The salaries established by the board under subparagraph  
3 (A) shall not exceed the highest comparable salary for a position  
4 of that type, as determined by the surveys conducted pursuant to  
5 subparagraph (A).

6 (C) The Department of Human Resources shall review the  
7 methodology used in the surveys conducted pursuant to  
8 subparagraph (A).

9 (3) The positions described in paragraph (1) and subdivision (i)  
10 of Section 100500 shall not be subject to otherwise applicable  
11 provisions of the Government Code or the Public Contract Code  
12 and, for those purposes, the Exchange shall not be considered a  
13 state agency or public entity.

14 (n) Assess a charge on the qualified health plans offered by  
15 carriers that is reasonable and necessary to support the  
16 development, operations, and prudent cash management of the  
17 Exchange. This charge shall not affect the requirement under  
18 Section 1301 of the federal act that carriers charge the same  
19 premium rate for each qualified health plan whether offered inside  
20 or outside the Exchange.

21 (o) Authorize expenditures, as necessary, from the California  
22 Health Trust Fund to pay program expenses to administer the  
23 Exchange.

24 (p) Keep an accurate accounting of all activities, receipts, and  
25 expenditures, and annually submit to the United States Secretary  
26 of Health and Human Services a report concerning that accounting.  
27 Commencing January 1, 2016, the board shall conduct an annual  
28 audit.

29 (q) (1) Annually prepare a written report on the implementation  
30 and performance of the Exchange functions during the preceding  
31 fiscal year, including, at a minimum, the manner in which funds  
32 were expended and the progress toward, and the achievement of,  
33 the requirements of this title. This report shall be transmitted to  
34 the Legislature and the Governor and shall be made available to  
35 the public on the Internet Web site of the Exchange. A report made  
36 to the Legislature pursuant to this subdivision shall be submitted  
37 pursuant to Section 9795.

38 (2) In addition to the report described in paragraph (1), the board  
39 shall be responsive to requests for additional information from the  
40 Legislature, including providing testimony and commenting on

1 proposed state legislation or policy issues. The Legislature finds  
2 and declares that activities including, but not limited to, responding  
3 to legislative or executive inquiries, tracking and commenting on  
4 legislation and regulatory activities, and preparing reports on the  
5 implementation of this title and the performance of the Exchange,  
6 are necessary state requirements and are distinct from the  
7 promotion of legislative or regulatory modifications referred to in  
8 subdivision (d) of Section 100520.

9 (r) Maintain enrollment and expenditures to ensure that  
10 expenditures do not exceed the amount of revenue in the fund, and  
11 if sufficient revenue is not available to pay estimated expenditures,  
12 institute appropriate measures to ensure fiscal solvency.

13 (s) Exercise all powers reasonably necessary to carry out and  
14 comply with the duties, responsibilities, and requirements of this  
15 act and the federal act.

16 (t) Consult with stakeholders relevant to carrying out the  
17 activities under this title, including, but not limited to, all of the  
18 following:

19 (1) Health care consumers who are enrolled in health plans.

20 (2) Individuals and entities with experience in facilitating  
21 enrollment in health plans.

22 (3) Representatives of small businesses and self-employed  
23 individuals.

24 (4) The State Medi-Cal Director.

25 (5) Advocates for enrolling hard-to-reach populations.

26 (u) Facilitate the purchase of qualified health plans in the  
27 Exchange by qualified individuals and qualified small employers  
28 no later than January 1, 2014.

29 (v) Report, or contract with an independent entity to report, to  
30 the Legislature by December 1, 2018, on whether to adopt the  
31 option in Section 1312(c)(3) of the federal act to merge the  
32 individual and small employer markets. In its report, the board  
33 shall provide information, based on at least two years of data from  
34 the Exchange, on the potential impact on rates paid by individuals  
35 and by small employers in a merged individual and small employer  
36 market, as compared to the rates paid by individuals and small  
37 employers if a separate individual and small employer market is  
38 maintained. A report made pursuant to this subdivision shall be  
39 submitted pursuant to Section 9795.

1 (w) With respect to the SHOP Program, collect premiums and  
2 administer all other necessary and related tasks, including, but not  
3 limited to, enrollment and plan payment, in order to make the  
4 offering of employee plan choice as simple as possible for qualified  
5 small employers.

6 (x) Require carriers participating in the Exchange to immediately  
7 notify the Exchange, under the terms and conditions established  
8 by the board when an individual is or will be enrolled in or  
9 disenrolled from any qualified health plan offered by the carrier.

10 (y) Ensure that the Exchange provides oral interpretation  
11 services in any language for individuals seeking coverage through  
12 the Exchange and makes available a toll-free telephone number  
13 for the hearing and speech impaired. The board shall ensure that  
14 written information made available by the Exchange is presented  
15 in a plainly worded, easily understandable format and made  
16 available in prevalent languages.

17 (z) This section shall become operative only if Section 4 of the  
18 act that added this section becomes inoperative pursuant to  
19 subdivision (z) of that Section 4.

20 SEC. 3. Section 1357.503 of the Health and Safety Code is  
21 amended to read:

22 1357.503. (a) (1) On and after October 1, 2013, a plan shall  
23 fairly and affirmatively offer, market, and sell all of the plan's  
24 small employer health care service plan contracts for plan years  
25 on or after January 1, 2014, to all small employers in each service  
26 area in which the plan provides or arranges for the provision of  
27 health care services.

28 (2) On and after October 1, 2013, a plan shall make available  
29 to each small employer all small employer health care service plan  
30 contracts that the plan offers and sells to small employers or to  
31 associations that include small employers in this state for plan  
32 years on or after January 1, 2014. Health coverage through an  
33 association that is not related to employment shall be considered  
34 individual coverage pursuant to Section 144.102(c) of Title 45 of  
35 the Code of Federal Regulations.

36 (3) A plan that offers qualified health plans through the  
37 Exchange shall be deemed to be in compliance with paragraphs  
38 (1) and (2) with respect to small employer health care service plan  
39 contracts offered through the Exchange in those geographic regions  
40 in which the plan offers plan contracts through the Exchange.



1 (b) A plan shall provide enrollment periods consistent with  
2 PPACA and described in Section 155.725 of Title 45 of the Code  
3 of Federal Regulations. Commencing January 1, 2014, a plan shall  
4 provide special enrollment periods consistent with the special  
5 enrollment periods described in Section 1399.849, to the extent  
6 permitted by PPACA, except for the triggering events identified  
7 in paragraphs (d)(3) and (d)(6) of Section 155.420 of Title 45 of  
8 the Code of Federal Regulations with respect to plan contracts  
9 offered through the Exchange.

10 (c) No plan or solicitor shall induce or otherwise encourage a  
11 small employer to separate or otherwise exclude an eligible  
12 employee from a health care service plan contract that is provided  
13 in connection with employee's employment or membership in a  
14 guaranteed association.

15 (d) Every plan shall file with the director the reasonable  
16 employee participation requirements and employer contribution  
17 requirements that will be applied in offering its plan contracts.  
18 Participation requirements shall be applied uniformly among all  
19 small employer groups, except that a plan may vary application  
20 of minimum employee participation requirements by the size of  
21 the small employer group and whether the employer contributes  
22 100 percent of the eligible employee's premium. Employer  
23 contribution requirements shall not vary by employer size. A health  
24 care service plan shall not establish a participation requirement  
25 that (1) requires a person who meets the definition of a dependent  
26 in Section 1357.500 to enroll as a dependent if he or she is  
27 otherwise eligible for coverage and wishes to enroll as an eligible  
28 employee and (2) allows a plan to reject an otherwise eligible small  
29 employer because of the number of persons that waive coverage  
30 due to coverage through another employer. Members of an  
31 association eligible for health coverage under subdivision (m) of  
32 Section 1357.500, but not electing any health coverage through  
33 the association, shall not be counted as eligible employees for  
34 purposes of determining whether the guaranteed association meets  
35 a plan's reasonable participation standards.

36 (e) The plan shall not reject an application from a small  
37 employer for a small employer health care service plan contract  
38 if all of the following conditions are met:

39 (1) The small employer offers health benefits to 100 percent of  
40 its eligible employees. Employees who waive coverage on the

1 grounds that they have other group coverage shall not be counted  
2 as eligible employees.

3 (2) The small employer agrees to make the required premium  
4 payments.

5 (3) The small employer agrees to inform the small employer's  
6 employees of the availability of coverage and the provision that  
7 those not electing coverage must wait until the next open  
8 enrollment or a special enrollment period to obtain coverage  
9 through the group if they later decide they would like to have  
10 coverage.

11 (4) The employees and their dependents who are to be covered  
12 by the plan contract work or reside in the service area in which  
13 the plan provides or otherwise arranges for the provision of health  
14 care services.

15 (f) No plan or solicitor shall, directly or indirectly, engage in  
16 the following activities:

17 (1) Encourage or direct small employers to refrain from filing  
18 an application for coverage with a plan because of the health status,  
19 claims experience, industry, occupation of the small employer, or  
20 geographic location provided that it is within the plan's approved  
21 service area.

22 (2) Encourage or direct small employers to seek coverage from  
23 another plan because of the health status, claims experience,  
24 industry, occupation of the small employer, or geographic location  
25 provided that it is within the plan's approved service area.

26 (3) Employ marketing practices or benefit designs that will have  
27 the effect of discouraging the enrollment of individuals with  
28 significant health needs or discriminate based on an individual's  
29 race, color, national origin, present or predicted disability, age,  
30 sex, gender identity, sexual orientation, expected length of life,  
31 degree of medical dependency, quality of life, or other health  
32 conditions.

33 (g) A plan shall not, directly or indirectly, enter into any  
34 contract, agreement, or arrangement with a solicitor that provides  
35 for or results in the compensation paid to a solicitor for the sale of  
36 a health care service plan contract to be varied because of the health  
37 status, claims experience, industry, occupation, or geographic  
38 location of the small employer. This subdivision does not apply  
39 to a compensation arrangement that provides compensation to a  
40 solicitor on the basis of percentage of premium, provided that the

percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the small employer.

(h) (1) A policy or contract that covers a small employer, as defined in Section 1304(b) of PPACA and in Section 1357.500, shall not establish rules for eligibility, including continued eligibility, of an individual, or dependent of an individual, to enroll under the terms of the policy or contract based on any of the following health status-related factors:

- (A) Health status.
- (B) Medical condition, including physical and mental illnesses.
- (C) Claims experience.
- (D) Receipt of health care.
- (E) Medical history.
- (F) Genetic information.
- (G) Evidence of insurability, including conditions arising out of acts of domestic violence.
- (H) Disability.
- (I) Any other health status-related factor as determined by any federal regulations, rules, or guidance issued pursuant to Section 2705 of the federal Public Health Service Act.

(2) Notwithstanding Section 1389.1, a health care service plan shall not require an eligible employee or dependent to fill out a health assessment or medical questionnaire prior to enrollment under a small employer health care service plan contract. A health care service plan shall not acquire or request information that relates to a health status-related factor from the applicant or his or her dependent or any other source prior to enrollment of the individual.

(i) (1) A health care service plan shall consider as a single risk pool for rating purposes in the small employer market the claims experience of all enrollees in all nongrandfathered small employer health care service plan contracts *benefit plans* offered by the health care service plan in this state and all insureds in all nongrandfathered health benefit plans subject to Chapter 8.01 (commencing with Section 10753) of Part 2 of Division 2 of the Insurance Code offered by a health insurer that is a corporate affiliate, subsidiary, or parent of the plan, state, whether offered as health care service plan contracts or health insurance policies, including those insureds and enrollees who enroll in coverage

1 through the Exchange and insureds and enrollees ~~who enroll in~~  
2 ~~coverage covered by the health care service plan~~ outside of the  
3 Exchange.

4 (2) At least each calendar year, and no more frequently than  
5 each calendar quarter, a health care service plan shall establish an  
6 index rate for the small employer market in the state based on the  
7 total combined claims costs for providing essential health benefits,  
8 as defined pursuant to Section 1302 of PPACA and Section  
9 1367.005, within the single risk pool required under paragraph  
10 (1). The index rate shall be adjusted on a marketwide basis based  
11 on the total expected marketwide payments and charges under the  
12 risk adjustment and reinsurance programs established for the state  
13 pursuant to Sections 1343 and 1341 of PPACA and Exchange user  
14 fees, as described in subdivision (d) of Section 156.80 of Title 45  
15 of the Code of Federal Regulations. The premium rate for all of  
16 the nongrandfathered small employer health care service plan  
17 contracts and nongrandfathered health benefit plans within the  
18 single risk pool required under paragraph (1) shall use the  
19 ~~applicable index rate, as adjusted for total expected marketwide~~  
20 ~~payments and charges under the risk adjustment and reinsurance~~  
21 ~~programs established for the state pursuant to Sections 1343 and~~  
22 ~~1341 of PPACA, marketwide adjusted index rate~~, subject only to  
23 the adjustments permitted under paragraph (3).

24 (3) A health care service plan may vary premium rates for a  
25 particular nongrandfathered small employer health care service  
26 plan contract from its index rate based only on the following  
27 actuarially justified plan-specific factors:

28 (A) The actuarial value and cost-sharing design of the plan  
29 contract.

30 (B) The plan contract's provider network, delivery system  
31 characteristics, and utilization management practices.

32 (C) The benefits provided under the plan contract that are in  
33 addition to the essential health benefits, as defined pursuant to  
34 Section 1302 of PPACA. These additional benefits shall be pooled  
35 with similar benefits within the single risk pool required under  
36 paragraph (1) and the claims experience from those benefits shall  
37 be utilized to determine rate variations for plan contracts that offer  
38 those benefits in addition to essential health benefits.

1 (D) With respect to catastrophic plans, as described in subsection  
2 (e) of Section 1302 of PPACA, the expected impact of the specific  
3 eligibility categories for those plans.

4 (E) Administrative costs, excluding any user fees required by  
5 the Exchange.

6 (j) A plan shall comply with the requirements of Section 1374.3.

7 (k) (1) Except as provided in paragraph (2), if Section 2702 of  
8 the federal Public Health Service Act (42 U.S.C. Sec. 300gg-1),  
9 as added by Section 1201 of PPACA, is repealed, this section shall  
10 become inoperative 12 months after the repeal date, in which case  
11 health care service plans subject to this section shall instead be  
12 governed by Section 1357.03 to the extent permitted by federal  
13 law, and all references in this article to this section shall instead  
14 refer to Section 1357.03 except for purposes of paragraph (2).

15 (2) Subdivision (b) shall remain operative with respect to health  
16 care service plan contracts offered through the Exchange.

17 SEC. 4. Section 1366.6 of the Health and Safety Code, as  
18 amended by Section 8 of Chapter 5 of the First Extraordinary  
19 Session of the Statutes of 2013, is amended to read:

20 1366.6. (a) For purposes of this section, the following  
21 definitions shall apply:

22 (1) “Exchange” means the California Health Benefit Exchange  
23 established in Title 22 (commencing with Section 100500) of the  
24 Government Code.

25 (2) “Federal act” means the federal Patient Protection and  
26 Affordable Care Act (Public Law 111-148), as amended by the  
27 federal Health Care and Education Reconciliation Act of 2010  
28 (Public Law 111-152), and any amendments to, or regulations or  
29 guidance issued under, those acts.

30 (3) “Qualified health plan” has the same meaning as that term  
31 is defined in Section 1301 of the federal act.

32 (4) “Small employer” has the same meaning as that term is  
33 defined in Section 1357.500.

34 (b) (1) Health care service plans participating in the individual  
35 market of the Exchange shall fairly and affirmatively offer, market,  
36 and sell in the individual market of the Exchange at least one  
37 product within each of the five levels of coverage contained in  
38 subsections (d) and (e) of Section 1302 of the federal act. Health  
39 care service plans participating in the Small Business Health  
40 Options Program (SHOP Program) of the Exchange, established

1 pursuant to subdivision (m) of Section 100504 of the Government  
2 Code, shall fairly and affirmatively offer, market, and sell in the  
3 SHOP Program at least one product within each of the four levels  
4 of coverage contained in subsection (d) of Section 1302 of the  
5 federal act.

6 (2) The board established under Section 100500 of the  
7 Government Code may require plans to sell additional products  
8 within each of the levels of coverage identified in paragraph (1).

9 (3) This subdivision shall not apply to a plan that solely offers  
10 supplemental coverage in the Exchange under paragraph (10) of  
11 subdivision (a) of Section 100504 of the Government Code.

12 (4) This subdivision shall not apply to a bridge plan product  
13 that meets the requirements of Section 100504.5 of the Government  
14 Code to the extent approved by the appropriate federal agency.

15 (c) (1) Health care service plans participating in the Exchange  
16 that sell any products outside the Exchange shall do both of the  
17 following:

18 (A) Fairly and affirmatively offer, market, and sell all products  
19 made available to individuals in the Exchange to individuals  
20 purchasing coverage outside the Exchange.

21 (B) Fairly and affirmatively offer, market, and sell all products  
22 made available to small employers in the Exchange to small  
23 employers purchasing coverage outside the Exchange.

24 (2) For purposes of this subdivision, “product” does not include  
25 contracts entered into pursuant to Part 6.2 (commencing with  
26 Section 12693) of Division 2 of the Insurance Code between the  
27 Managed Risk Medical Insurance Board and health care service  
28 plans for enrolled Healthy Families beneficiaries or to contracts  
29 entered into pursuant to Chapter 7 (commencing with Section  
30 14000) of, or Chapter 8 (commencing with Section 14200) of, Part  
31 3 of Division 9 of the Welfare and Institutions Code between the  
32 State Department of Health Care Services and health care service  
33 plans for enrolled Medi-Cal beneficiaries, or for contracts with  
34 bridge plan products that meet the requirements of Section  
35 100504.5 of the Government Code.

36 (d) (1) Commencing January 1, 2014, a health care service plan  
37 shall, with respect to individual plan contracts that cover hospital,  
38 medical, or surgical benefits, only sell the five levels of coverage  
39 contained in subsections (d) and (e) of Section 1302 of the federal  
40 act, except that a health care service plan that does not participate

1 in the Exchange shall, with respect to individual plan contracts  
2 that cover hospital, medical, or surgical benefits, only sell the four  
3 levels of coverage contained in subsection (d) of Section 1302 of  
4 the federal act.

5 (2) Commencing January 1, 2014, a health care service plan  
6 shall, with respect to small employer plan contracts that cover  
7 hospital, medical, or surgical expenses, only sell the four levels of  
8 coverage contained in subsection (d) of Section 1302 of the federal  
9 act.

10 (e) Commencing January 1, 2014, a health care service plan  
11 that does not participate in the Exchange shall, with respect to  
12 individual or small employer plan contracts that cover hospital,  
13 medical, or surgical benefits, offer at least one standardized product  
14 that has been designated by the Exchange in each of the four levels  
15 of coverage contained in subsection (d) of Section 1302 of the  
16 federal act. This subdivision shall only apply if the board of the  
17 Exchange exercises its authority under subdivision (c) of Section  
18 100504 of the Government Code. Nothing in this subdivision shall  
19 require a plan that does not participate in the Exchange to offer  
20 standardized products in the small employer market if the plan  
21 only sells products in the individual market. Nothing in this  
22 subdivision shall require a plan that does not participate in the  
23 Exchange to offer standardized products in the individual market  
24 if the plan only sells products in the small employer market. This  
25 subdivision shall not be construed to prohibit the plan from offering  
26 other products provided that it complies with subdivision (d).

27 (f) For purposes of this section, a bridge plan product shall mean  
28 an individual health benefit plan, as defined in subdivision (f) of  
29 Section 1399.845, that is offered by a health care service plan  
30 licensed under this chapter that contracts with the Exchange  
31 pursuant to Title 22 (commencing with Section 100500) of the  
32 Government Code.

33 (g) This section shall become inoperative on the October 1 that  
34 is five years after the date that federal approval of the bridge plan  
35 option occurs, and, as of the second January 1 thereafter, is  
36 repealed, unless a later enacted statute that is enacted before that  
37 date deletes or extends the dates on which it becomes inoperative  
38 and is repealed.

SEC. 5. Section 1366.6 of the Health and Safety Code, as added by Section 9 of Chapter 5 of the First Extraordinary Session of the Statutes of 2013, is amended to read:

1366.6. (a) For purposes of this section, the following definitions shall apply:

(1) “Exchange” means the California Health Benefit Exchange established in Title 22 (commencing with Section 100500) of the Government Code.

(2) “Federal act” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments to, or regulations or guidance issued under, those acts.

(3) “Qualified health plan” has the same meaning as that term is defined in Section 1301 of the federal act.

(4) “Small employer” has the same meaning as that term is defined in Section 1357.500.

(b) (1) Health care service plans participating in the individual market of the Exchange shall fairly and affirmatively offer, market, and sell in the individual market of the Exchange at least one product within each of the five levels of coverage contained in subsections (d) and (e) of Section 1302 of the federal act. Health care service plans participating in the Small Business Health Options Program (SHOP Program) of the Exchange, established pursuant to subdivision (m) of Section 100504 of the Government Code, shall fairly and affirmatively offer, market, and sell in the SHOP Program at least one product within each of the four levels of coverage contained in subsection (d) of Section 1302 of the federal act.

(2) The board established under Section 100500 of the Government Code may require plans to sell additional products within each of the levels of coverage identified in paragraph (1).

(3) This subdivision shall not apply to a plan that solely offers supplemental coverage in the Exchange under paragraph (10) of subdivision (a) of Section 100504 of the Government Code.

(c) (1) Health care service plans participating in the Exchange that sell any products outside the Exchange shall do both of the following:



1 (A) Fairly and affirmatively offer, market, and sell all products  
2 made available to individuals in the Exchange to individuals  
3 purchasing coverage outside the Exchange.

4 (B) Fairly and affirmatively offer, market, and sell all products  
5 made available to small employers in the Exchange to small  
6 employers purchasing coverage outside the Exchange.

7 (2) For purposes of this subdivision, “product” does not include  
8 contracts entered into pursuant to Part 6.2 (commencing with  
9 Section 12693) of Division 2 of the Insurance Code between the  
10 Managed Risk Medical Insurance Board and health care service  
11 plans for enrolled Healthy Families beneficiaries or to contracts  
12 entered into pursuant to Chapter 7 (commencing with Section  
13 14000) of, or Chapter 8 (commencing with Section 14200) of, Part  
14 3 of Division 9 of the Welfare and Institutions Code between the  
15 State Department of Health Care Services and health care service  
16 plans for enrolled Medi-Cal beneficiaries.

17 (d) (1) Commencing January 1, 2014, a health care service plan  
18 shall, with respect to individual plan contracts that cover hospital,  
19 medical, or surgical benefits, only sell the five levels of coverage  
20 contained in subsections (d) and (e) of Section 1302 of the federal  
21 act, except that a health care service plan that does not participate  
22 in the Exchange shall, with respect to individual plan contracts  
23 that cover hospital, medical, or surgical benefits, only sell the four  
24 levels of coverage contained in subsection (d) of Section 1302 of  
25 the federal act.

26 (2) Commencing January 1, 2014, a health care service plan  
27 shall, with respect to small employer plan contracts that cover  
28 hospital, medical, or surgical expenses, only sell the four levels of  
29 coverage contained in subsection (d) of Section 1302 of the federal  
30 act.

31 (e) Commencing January 1, 2014, a health care service plan  
32 that does not participate in the Exchange shall, with respect to  
33 individual or small employer plan contracts that cover hospital,  
34 medical, or surgical benefits, offer at least one standardized product  
35 that has been designated by the Exchange in each of the four levels  
36 of coverage contained in subdivision (d) of Section 1302 of the  
37 federal act. This subdivision shall only apply if the board of the  
38 Exchange exercises its authority under subdivision (c) of Section  
39 100504 of the Government Code. Nothing in this subdivision shall  
40 require a plan that does not participate in the Exchange to offer

1 standardized products in the small employer market if the plan  
2 only sells products in the individual market. Nothing in this  
3 subdivision shall require a plan that does not participate in the  
4 Exchange to offer standardized products in the individual market  
5 if the plan only sells products in the small employer market. This  
6 subdivision shall not be construed to prohibit the plan from offering  
7 other products provided that it complies with subdivision (d).

8 (f) This section shall become operative only if Section 8 of the  
9 act that added this section becomes inoperative pursuant to  
10 subdivision (g) of that Section 8.

11 SEC. 6. Section 1367.005 of the Health and Safety Code is  
12 amended to read:

13 1367.005. (a) An individual or small group health care service  
14 plan contract issued, amended, or renewed on or after January 1,  
15 2014, shall, at a minimum, include coverage for essential health  
16 benefits pursuant to PPACA and as outlined in this section. For  
17 purposes of this section, “essential health benefits” means all of  
18 the following:

19 (1) Health benefits within the categories identified in Section  
20 1302(b) of PPACA: ambulatory patient services, emergency  
21 services, hospitalization, maternity and newborn care, mental health  
22 and substance use disorder services, including behavioral health  
23 treatment, prescription drugs, rehabilitative and habilitative services  
24 and devices, laboratory services, preventive and wellness services  
25 and chronic disease management, and pediatric services, including  
26 oral and vision care.

27 (2) (A) The health benefits covered by the Kaiser Foundation  
28 Health Plan Small Group HMO 30 plan (federal health product  
29 identification number 40513CA035) as this plan was offered during  
30 the first quarter of 2012, as follows, regardless of whether the  
31 benefits are specifically referenced in the evidence of coverage or  
32 plan contract for that plan:

33 (i) Medically necessary basic health care services, as defined  
34 in subdivision (b) of Section 1345 and in Section 1300.67 of Title  
35 28 of the California Code of Regulations.

36 (ii) The health benefits mandated to be covered by the plan  
37 pursuant to statutes enacted before December 31, 2011, as  
38 described in the following sections: Sections 1367.002, 1367.06,  
39 and 1367.35 (preventive services for children); Section 1367.25  
40 (prescription drug coverage for contraceptives); Section 1367.45

(AIDS vaccine); Section 1367.46 (HIV testing); Section 1367.51 (diabetes); Section 1367.54 (alpha feto protein testing); Section 1367.6 (breast cancer screening); Section 1367.61 (prosthetics for laryngectomy); Section 1367.62 (maternity hospital stay); Section 1367.63 (reconstructive surgery); Section 1367.635 (mastectomies); Section 1367.64 (prostate cancer); Section 1367.65 (mammography); Section 1367.66 (cervical cancer); Section 1367.665 (cancer screening tests); Section 1367.67 (osteoporosis); Section 1367.68 (surgical procedures for jaw bones); Section 1367.71 (anesthesia for dental); Section 1367.9 (conditions attributable to diethylstilbestrol); Section 1368.2 (hospice care); Section 1370.6 (cancer clinical trials); Section 1371.5 (emergency response ambulance or ambulance transport services); subdivision (b) of Section 1373 (sterilization operations or procedures); Section 1373.4 (inpatient hospital and ambulatory maternity); Section 1374.56 (phenylketonuria); Section 1374.17 (organ transplants for HIV); Section 1374.72 (mental health parity); and Section 1374.73 (autism/behavioral health treatment).

(iii) Any other benefits mandated to be covered by the plan pursuant to statutes enacted before December 31, 2011, as described in those statutes.

(iv) The health benefits covered by the plan that are not otherwise required to be covered under this chapter, to the extent required pursuant to Sections 1367.18, 1367.21, 1367.215, 1367.22, 1367.24, and 1367.25, and Section 1300.67.24 of Title 28 of the California Code of Regulations.

(v) Any other health benefits covered by the plan that are not otherwise required to be covered under this chapter.

(B) Where there are any conflicts or omissions in the plan identified in subparagraph (A) as compared with the requirements for health benefits under this chapter that were enacted prior to December 31, 2011, the requirements of this chapter shall be controlling, except as otherwise specified in this section.

(C) Notwithstanding subparagraph (B) or any other provision of this section, the home health services benefits covered under the plan identified in subparagraph (A) shall be deemed to not be in conflict with this chapter.

(D) For purposes of this section, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) shall apply to a contract subject to this

1 section. Coverage of mental health and substance use disorder  
2 services pursuant to this paragraph, along with any scope and  
3 duration limits imposed on the benefits, shall be in compliance  
4 with the Paul Wellstone and Pete Domenici Mental Health Parity  
5 and Addiction Equity Act of 2008 (Public Law 110-343), and all  
6 rules, regulations, or guidance issued pursuant to Section 2726 of  
7 the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26).

8 (3) With respect to habilitative services, in addition to any  
9 habilitative services identified in paragraph (2), coverage shall  
10 also be provided as required by federal rules, regulations, and  
11 guidance issued pursuant to Section 1302(b) of PPACA.  
12 Habilitative services shall be covered under the same terms and  
13 conditions applied to rehabilitative services under the plan contract.

14 (4) With respect to pediatric vision care, the same health benefits  
15 for pediatric vision care covered under the Federal Employees  
16 Dental and Vision Insurance Program vision plan with the largest  
17 national enrollment as of the first quarter of 2012. The pediatric  
18 vision care benefits covered pursuant to this paragraph shall be in  
19 addition to, and shall not replace, any vision services covered under  
20 the plan identified in paragraph (2).

21 (5) With respect to pediatric oral care, the same health benefits  
22 for pediatric oral care covered under the dental plan available to  
23 subscribers of the Healthy Families Program in 2011–12, including  
24 the provision of medically necessary orthodontic care provided  
25 pursuant to the federal Children’s Health Insurance Program  
26 Reauthorization Act of 2009. The pediatric oral care benefits  
27 covered pursuant to this paragraph shall be in addition to, and shall  
28 not replace, any dental or orthodontic services covered under the  
29 plan identified in paragraph (2).

30 (b) Treatment limitations imposed on health benefits described  
31 in this section shall be no greater than the treatment limitations  
32 imposed by the corresponding plans identified in subdivision (a),  
33 subject to the requirements set forth in paragraph (2) of subdivision  
34 (a).

35 (c) Except as provided in subdivision (d), nothing in this section  
36 shall be construed to permit a health care service plan to make  
37 substitutions for the benefits required to be covered under this  
38 section, regardless of whether those substitutions are actuarially  
39 equivalent.

1 (d) To the extent permitted under Section 1302 of PPACA and  
2 any rules, regulations, or guidance issued pursuant to that section,  
3 and to the extent that substitution would not create an obligation  
4 for the state to defray costs for any individual, a plan may substitute  
5 its prescription drug formulary for the formulary provided under  
6 the plan identified in subdivision (a) as long as the coverage for  
7 prescription drugs complies with the sections referenced in clauses  
8 (ii) and (iv) of subparagraph (A) of paragraph (2) of subdivision  
9 (a) that apply to prescription drugs.

10 (e) No health care service plan, or its agent, solicitor, or  
11 representative, shall issue, deliver, renew, offer, market, represent,  
12 or sell any product, contract, or discount arrangement as compliant  
13 with the essential health benefits requirement in federal law, unless  
14 it meets all of the requirements of this section.

15 (f) This section shall apply regardless of whether the plan  
16 contract is offered inside or outside the California Health Benefit  
17 Exchange created by Section 100500 of the Government Code.

18 (g) Nothing in this section shall be construed to exempt a plan  
19 or a plan contract from meeting other applicable requirements of  
20 law.

21 (h) This section shall not be construed to prohibit a plan contract  
22 from covering additional benefits, including, but not limited to,  
23 spiritual care services that are tax deductible under Section 213 of  
24 the Internal Revenue Code.

25 (i) Subdivision (a) shall not apply to any of the following:

26 (1) A specialized health care service plan contract.

27 (2) A Medicare supplement plan.

28 (3) A plan contract that qualifies as a grandfathered health plan  
29 under Section 1251 of PPACA or any rules, regulations, or  
30 guidance issued pursuant to that section.

31 (j) Nothing in this section shall be implemented in a manner  
32 that conflicts with a requirement of PPACA.

33 (k) This section shall be implemented only to the extent essential  
34 health benefits are required pursuant to PPACA.

35 (l) An essential health benefit is required to be provided under  
36 this section only to the extent that federal law does not require the  
37 state to defray the costs of the benefit.

38 (m) Nothing in this section shall obligate the state to incur costs  
39 for the coverage of benefits that are not essential health benefits  
40 as defined in this section.

1 (n) A plan is not required to cover, under this section, changes  
2 to health benefits that are the result of statutes enacted on or after  
3 December 31, 2011.

4 (o) (1) The department may adopt emergency regulations  
5 implementing this section. The department may, on a one-time  
6 basis, readopt any emergency regulation authorized by this section  
7 that is the same as, or substantially equivalent to, an emergency  
8 regulation previously adopted under this section.

9 (2) The initial adoption of emergency regulations implementing  
10 this section and the readoption of emergency regulations authorized  
11 by this subdivision shall be deemed an emergency and necessary  
12 for the immediate preservation of the public peace, health, safety,  
13 or general welfare. The initial emergency regulations and the  
14 readoption of emergency regulations authorized by this section  
15 shall be submitted to the Office of Administrative Law for filing  
16 with the Secretary of State and each shall remain in effect for no  
17 more than 180 days, by which time final regulations may be  
18 adopted.

19 (3) The director shall consult with the Insurance Commissioner  
20 to ensure consistency and uniformity in the development of  
21 regulations under this subdivision.

22 (4) This subdivision shall become inoperative on March 1, 2016.

23 (p) For purposes of this section, the following definitions shall  
24 apply:

25 (1) “Habilitative services” means medically necessary health  
26 care services and health care devices that assist an individual in  
27 partially or fully acquiring or improving skills and functioning and  
28 that are necessary to address a health condition, to the maximum  
29 extent practical. These services address the skills and abilities  
30 needed for functioning in interaction with an individual’s  
31 environment. Examples of health care services that are not  
32 habilitative services include, but are not limited to, respite care,  
33 day care, recreational care, residential treatment, social services,  
34 custodial care, or education services of any kind, including, but  
35 not limited to, vocational training. Habilitative services shall be  
36 covered under the same terms and conditions applied to  
37 rehabilitative services under the plan contract.

38 (2) (A) “Health benefits,” unless otherwise required to be  
39 defined pursuant to federal rules, regulations, or guidance issued  
40 pursuant to Section 1302(b) of PPACA, means health care items

1 or services for the diagnosis, cure, mitigation, treatment, or  
2 prevention of illness, injury, disease, or a health condition,  
3 including a behavioral health condition.

4 (B) “Health benefits” does not mean any cost-sharing  
5 requirements such as copayments, coinsurance, or deductibles.

6 (3) “PPACA” means the federal Patient Protection and  
7 Affordable Care Act (Public Law 111-148), as amended by the  
8 federal Health Care and Education Reconciliation Act of 2010  
9 (Public Law 111-152), and any rules, regulations, or guidance  
10 issued thereunder.

11 (4) “Small group health care service plan contract” means a  
12 group health care service plan contract issued to a small employer,  
13 as defined in Section 1357.500.

14 SEC. 7. Section 1367.006 of the Health and Safety Code is  
15 amended to read:

16 1367.006. (a) This section shall apply to nongrandfathered  
17 individual and group health care service plan contracts that provide  
18 coverage for essential health benefits, as defined in Section  
19 1367.005, and that are issued, amended, or renewed on or after  
20 January 1, 2015.

21 (b) (1) For nongrandfathered health care service plan contracts  
22 in the individual or small group markets, a health care service plan  
23 contract, except a specialized health care service plan contract,  
24 that is issued, amended, or renewed on or after January 1, 2015,  
25 shall provide for a limit on annual out-of-pocket expenses for all  
26 covered benefits that meet the definition of essential health benefits  
27 in Section 1367.005, including out-of-network emergency care  
28 consistent with Section 1371.4.

29 (2) For nongrandfathered health care service plan contracts in  
30 the large group market, a health care service plan contract, except  
31 a specialized health care service plan contract, that is issued,  
32 amended, or renewed on or after January 1, 2015, shall provide  
33 for a limit on annual out-of-pocket expenses for covered benefits,  
34 including out-of-network emergency care consistent with Section  
35 1371.4. This limit shall only apply to essential health benefits, as  
36 defined in Section 1367.005, that are covered under the plan to  
37 the extent that this provision does not conflict with federal law or  
38 guidance on out-of-pocket maximums for nongrandfathered health  
39 care service plan contracts in the large group market.

(c) (1) The limit described in subdivision (b) shall not exceed the limit described in Section 1302(c) of PPACA, and any subsequent rules, regulations, or guidance issued under that section.

(2) The limit described in subdivision (b) shall result in a total maximum out-of-pocket limit for all covered essential health benefits equal to the dollar amounts in effect under Section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 with the dollar amounts adjusted as specified in Section 1302(c)(1)(B) of PPACA.

(d) Nothing in this section shall be construed to affect the reduction in cost sharing for eligible enrollees described in Section 1402 of PPACA, and any subsequent rules, regulations, or guidance issued under that section.

(e) If an essential health benefit is offered or provided by a specialized health care service plan, the total annual out-of-pocket maximum for all covered essential benefits shall not exceed the limit in subdivision (b). This section shall not apply to a specialized health care service plan that does not offer an essential health benefit as defined in Section 1367.005.

(f) The maximum out-of-pocket limit shall apply to any copayment, coinsurance, deductible, and any other form of cost sharing for all covered benefits that meet the definition of essential health benefits in Section 1367.005.

(g) For nongrandfathered health plan contracts in the group market, “plan year” has the meaning set forth in Section 144.103 of Title 45 of the Code of Federal Regulations. For nongrandfathered health plan contracts sold in the individual market, “plan year” means the calendar year.

(h) “PPACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

SEC. 8. Section 1374.21 of the Health and Safety Code is amended to read:

1374.21. (a) No change in premium rates or changes in coverage stated in a group health care service plan contract shall become effective unless the plan has delivered in writing a notice indicating the change or changes at least 60 days prior to the contract renewal effective date.



1 (b) A health care service plan that declines to offer coverage to  
2 or denies enrollment for a large group applying for coverage shall,  
3 at the time of the denial of coverage, provide the applicant with  
4 the specific reason or reasons for the decision in writing, in clear,  
5 easily understandable language.

6 SEC. 9. Section 1385.03 of the Health and Safety Code is  
7 amended to read:

8 1385.03. (a) All health care service plans shall file with the  
9 department all required rate information for individual and small  
10 group health care service plan contracts at least 60 days prior to  
11 implementing any rate change.

12 (b) A plan shall disclose to the department all of the following  
13 for each individual and small group rate filing:

- 14 (1) Company name and contact information.
- 15 (2) Number of plan contract forms covered by the filing.
- 16 (3) Plan contract form numbers covered by the filing.
- 17 (4) Product type, such as a preferred provider organization or  
18 health maintenance organization.
- 19 (5) Segment type.
- 20 (6) Type of plan involved, such as for profit or not for profit.
- 21 (7) Whether the products are opened or closed.
- 22 (8) Enrollment in each plan contract and rating form.
- 23 (9) Enrollee months in each plan contract form.
- 24 (10) Annual rate.
- 25 (11) Total earned premiums in each plan contract form.
- 26 (12) Total incurred claims in each plan contract form.
- 27 (13) Average rate change initially requested.
- 28 (14) Review category: initial filing for new product, filing for  
29 existing product, or resubmission.
- 30 (15) Average rate of change.
- 31 (16) Effective date of rate change.
- 32 (17) Number of subscribers or enrollees affected by each plan  
33 contract form.
- 34 (18) The plan's overall annual medical trend factor assumptions  
35 in each rate filing for all benefits and by aggregate benefit category,  
36 including hospital inpatient, hospital outpatient, physician services,  
37 prescription drugs and other ancillary services, laboratory, and  
38 radiology. A plan may provide aggregated additional data that  
39 demonstrates or reasonably estimates year-to-year cost changes  
40 in specific benefit categories in the geographic regions listed in

Sections 1357.512 and 1399.855. A health plan that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the enrollees of the plan shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories that are, to the maximum extent possible, the same or similar to those used by other plans.

(19) The amount of the projected trend attributable to the use of services, price inflation, or fees and risk for annual plan contract trends by aggregate benefit category, such as hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology. A health plan that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the enrollees of the plan shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories that are, to the maximum extent possible, the same or similar to those used by other plans.

(20) A comparison of claims cost and rate of changes over time.

(21) Any changes in enrollee cost sharing over the prior year associated with the submitted rate filing.

(22) Any changes in enrollee benefits over the prior year associated with the submitted rate filing.

(23) The certification described in subdivision (b) of Section 1385.06.

(24) Any changes in administrative costs.

(25) Any other information required for rate review under PPACA.

(c) A health care service plan subject to subdivision (a) shall also disclose the following aggregate data for all rate filings submitted under this section in the individual and small group health plan markets:

(1) Number and percentage of rate filings reviewed by the following:

(A) Plan year.

(B) Segment type.

(C) Product type.

(D) Number of subscribers.

(E) Number of covered lives affected.

(2) The plan's average rate change by the following categories:

1 (A) Plan year.

2 (B) Segment type.

3 (C) Product type.

4 (3) Any cost containment and quality improvement efforts since  
5 the plan's last rate filing for the same category of health benefit  
6 plan. To the extent possible, the plan shall describe any significant  
7 new health care cost containment and quality improvement efforts  
8 and provide an estimate of potential savings together with an  
9 estimated cost or savings for the projection period.

10 (d) The department may require all health care service plans to  
11 submit all rate filings to the National Association of Insurance  
12 Commissioners' System for Electronic Rate and Form Filing  
13 (SERFF). Submission of the required rate filings to SERFF shall  
14 be deemed to be filing with the department for purposes of  
15 compliance with this section.

16 (e) A plan shall submit any other information required under  
17 PPACA. A plan shall also submit any other information required  
18 pursuant to any regulation adopted by the department to comply  
19 with this article.

20 SEC. 10. Section 1385.06 of the Health and Safety Code is  
21 amended to read:

22 1385.06. (a) A filing submitted under this article shall be  
23 actuarially sound.

24 (b) (1) The plan shall contract with an independent actuary or  
25 actuaries consistent with this section.

26 (2) A filing submitted under this article shall include a  
27 certification by an independent actuary or actuarial firm that the  
28 rate change is reasonable or unreasonable and, if unreasonable,  
29 that the justification for the change is based on accurate and sound  
30 actuarial assumptions and methodologies. Unless PPACA requires  
31 a certification of actuarial soundness for each large group contract,  
32 a filing submitted under Section 1385.04 shall include a  
33 certification by an independent actuary, as described in this section,  
34 that the aggregate or average rate increase is based on accurate  
35 and sound actuarial assumptions and methodologies.

36 (3) The actuary or actuarial firm acting under paragraph (2)  
37 shall not be an affiliate or a subsidiary of, nor in any way owned  
38 or controlled by, a health care service plan or a trade association  
39 of health care service plans. A board member, director, officer, or  
40 employee of the actuary or actuarial firm shall not serve as a board

1 member, director, or employee of a health care service plan. A  
2 board member, director, or officer of a health care service plan or  
3 a trade association of health care service plans shall not serve as  
4 a board member, director, officer, or employee of the actuary or  
5 actuarial firm.

6 (c) Nothing in this article shall be construed to permit the  
7 director to establish the rates charged subscribers and enrollees  
8 for covered health care services.

9 SEC. 11. Section 1385.07 of the Health and Safety Code is  
10 amended to read:

11 1385.07. (a) Notwithstanding Chapter 3.5 (commencing with  
12 Section 6250) of Division 7 of Title 1 of the Government Code,  
13 all information submitted under this article shall be made publicly  
14 available by the department except as provided in subdivision (b).

15 (b) The contracted rates between a health care service plan and  
16 a provider shall be deemed confidential information that shall not  
17 be made public by the department and are exempt from disclosure  
18 under the California Public Records Act (Chapter 3.5 (commencing  
19 with Section 6250) of Division 7 of Title 1 of the Government  
20 Code). The contracted rates between a health care service plan and  
21 a large group shall be deemed confidential information that shall  
22 not be made public by the department and are exempt from  
23 disclosure under the California Public Records Act (Chapter 3.5  
24 (commencing with Section 6250) of Division 7 of Title 1 of the  
25 Government Code).

26 (c) All information submitted to the department under this article  
27 shall be submitted electronically in order to facilitate review by  
28 the department and the public.

29 (d) In addition, the department and the health care service plan  
30 shall, at a minimum, make the following information readily  
31 available to the public on their Internet Web sites, in plain language  
32 and in a manner and format specified by the department, except  
33 as provided in subdivision (b). The information shall be made  
34 public for 60 days prior to the implementation of the rate change.  
35 The information shall include:

36 (1) Justifications for any unreasonable rate changes, including  
37 all information and supporting documentation as to why the rate  
38 change is justified.

39 (2) A plan's overall annual medical trend factor assumptions in  
40 each rate filing for all benefits.

1 (3) A health plan's actual costs, by aggregate benefit category  
2 to include hospital inpatient, hospital outpatient, physician services,  
3 prescription drugs and other ancillary services, laboratory, and  
4 radiology.

5 (4) The amount of the projected trend attributable to the use of  
6 services, price inflation, or fees and risk for annual plan contract  
7 trends by aggregate benefit category, such as hospital inpatient,  
8 hospital outpatient, physician services, prescription drugs and other  
9 ancillary services, laboratory, and radiology. A health plan that  
10 exclusively contracts with no more than two medical groups in the  
11 state to provide or arrange for professional medical services for  
12 the enrollees of the plan shall instead disclose the amount of its  
13 actual trend experience for the prior contract year by aggregate  
14 benefit category, using benefit categories that are, to the maximum  
15 extent possible, the same or similar to those used by other plans.

16 SEC. 12. Section 1385.11 of the Health and Safety Code is  
17 amended to read:

18 1385.11. (a) Whenever it appears to the department that any  
19 person has engaged, or is about to engage, in any act or practice  
20 constituting a violation of this article, including the filing of  
21 inaccurate or unjustified rates or inaccurate or unjustified rate  
22 information, the department may review the rate filing to ensure  
23 compliance with the law.

24 (b) The department may review other filings.

25 (c) The department shall accept and post to its Internet Web site  
26 any public comment on a rate change submitted to the department  
27 during the 60-day period described in subdivision (d) of Section  
28 1385.07.

29 (d) The department shall report to the Legislature at least  
30 quarterly on all unreasonable rate filings.

31 (e) The department shall post on its Internet Web site any  
32 modifications submitted by the plan to the proposed rate change,  
33 including any documentation submitted by the plan supporting  
34 those modifications.

35 (f) If the director makes a decision that an unreasonable rate  
36 change is not justified or that a rate filing contains inaccurate  
37 information, the department shall post that decision on its Internet  
38 Web site.

(g) Nothing in this article shall be construed to impair or impede the department's authority to administer or enforce any other provision of this chapter.

SEC. 13. Section 1389.25 of the Health and Safety Code is amended to read:

1389.25. (a) (1) This section shall apply only to a full service health care service plan offering health coverage in the individual market in California and shall not apply to a specialized health care service plan, a health care service plan contract in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), a health care service plan conversion contract offered pursuant to Section 1373.6, a health care service plan contract in the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code), or a health care service plan contract offered to a federally eligible defined individual under Article 4.6 (commencing with Section 1366.35).

(2) A local initiative, as defined in subdivision (v) of Section 53810 of Title 22 of the California Code of Regulations, that is awarded a contract by the State Department of Health Care Services pursuant to subdivision (b) of Section 53800 of Title 22 of the California Code of Regulations, shall not be subject to this section unless the plan offers coverage in the individual market to persons not covered by Medi-Cal or the Healthy Families Program.

(b) (1) No change in the premium rate or coverage for an individual plan contract shall become effective unless the plan has delivered a written notice of the change at least 15 days prior to the start of the annual enrollment period applicable to the contract or 60 days prior to the effective date of the contract renewal, whichever occurs earlier in the calendar year.

(2) The written notice required pursuant to paragraph (1) shall be delivered to the individual contractholder at his or her last address known to the plan. The notice shall state in italics and in 12-point type the actual dollar amount of the premium rate increase and the specific percentage by which the current premium will be increased. The notice shall describe in plain, understandable English any changes in the plan design or any changes in benefits, including a reduction in benefits or changes to waivers, exclusions, or conditions, and highlight this information by printing it in italics. The notice shall specify in a minimum of 10-point bold typeface,

1 the reason for a premium rate change or a change to the plan design  
2 or benefits.

3 *(c) If a plan rejects a dependent of a subscriber applying to be*  
4 *added to the subscriber's individual grandfathered health plan,*  
5 *rejects an applicant for a Medicare supplement plan contract due*  
6 *to the applicant having end-stage renal disease, or offers an*  
7 *individual grandfathered health plan to an applicant at a rate that*  
8 *is higher than the standard rate, the plan shall inform the applicant*  
9 *about the California Major Risk Medical Insurance Program*  
10 *(MRMIP) (Part 6.5 (commencing with Section 12700) of Division*  
11 *2 of the Insurance Code) and about the new coverage options, and*  
12 *the potential for subsidized coverage, through Covered California.*  
13 *The plan shall direct persons seeking more information to MRMIP,*  
14 *Covered California, plan or policy representatives, insurance*  
15 *agents, or an entity paid by Covered California to assist with health*  
16 *coverage enrollment, such as a navigator or an assister.*

17 ~~(e)~~

18 *(d) A notice provided pursuant to this section is a private and*  
19 *confidential communication and, at the time of application, the*  
20 *plan shall give the individual applicant the opportunity to designate*  
21 *the address for receipt of the written notice in order to protect the*  
22 *confidentiality of any personal or privileged information.*

23 *(e) For purposes of this section, the following definitions shall*  
24 *apply:*

25 *(1) "Covered California" means the California Health Benefit*  
26 *Exchange established pursuant to Section 100500 of the*  
27 *Government Code.*

28 *(2) "Grandfathered health plan" has the same meaning as that*  
29 *term is defined in Section 1251 of PPACA.*

30 *(3) "PPACA" means the federal Patient Protection and*  
31 *Affordable Care Act (Public Law 111-148), as amended by the*  
32 *federal Health Care and Education Reconciliation Act of 2010*  
33 *(Public Law 111-152), and any rules, regulations, or guidance*  
34 *issued pursuant to that law.*

35 SEC. 14. Section 1399.849 of the Health and Safety Code is  
36 amended to read:

37 1399.849. (a) (1) On and after October 1, 2013, a plan shall  
38 fairly and affirmatively offer, market, and sell all of the plan's  
39 health benefit plans that are sold in the individual market for policy  
40 years on or after January 1, 2014, to all individuals and dependents

1 in each service area in which the plan provides or arranges for the  
2 provision of health care services. A plan shall limit enrollment in  
3 individual health benefit plans to open enrollment periods and  
4 special enrollment periods as provided in subdivisions (c) and (d).

5 (2) A plan shall allow the subscriber of an individual health  
6 benefit plan to add a dependent to the subscriber's plan at the  
7 option of the subscriber, consistent with the open enrollment,  
8 annual enrollment, and special enrollment period requirements in  
9 this section.

10 (b) An individual health benefit plan issued, amended, or  
11 renewed on or after January 1, 2014, shall not impose any  
12 preexisting condition provision upon any individual.

13 (c) (1) A plan shall provide an initial open enrollment period  
14 from October 1, 2013, to March 31, 2014, inclusive, and annual  
15 enrollment periods for plan years on or after January 1, 2015, from  
16 October 15 to December 7, inclusive, of the preceding calendar  
17 year.

18 (2) Pursuant to Section 147.104(b)(2) of Title 45 of the Code  
19 of Federal Regulations, for individuals enrolled in noncalendar  
20 year individual health plan contracts, a plan shall provide a limited  
21 open enrollment period beginning on the date that is 30 calendar  
22 days prior to the date the policy year ends in 2014.

23 (d) (1) Subject to paragraph (2), commencing January 1, 2014,  
24 a plan shall allow an individual to enroll in or change individual  
25 health benefit plans as a result of the following triggering events:

26 (A) He or she or his or her dependent loses minimum essential  
27 coverage. For purposes of this paragraph, the following definitions  
28 shall apply:

29 (i) "Minimum essential coverage" has the same meaning as that  
30 term is defined in subsection (f) of Section 5000A of the Internal  
31 Revenue Code (26 U.S.C. Sec. 5000A).

32 (ii) "Loss of minimum essential coverage" includes, but is not  
33 limited to, loss of that coverage due to the circumstances described  
34 in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the  
35 Code of Federal Regulations and the circumstances described in  
36 Section 1163 of Title 29 of the United States Code. "Loss of  
37 minimum essential coverage" also includes loss of that coverage  
38 for a reason that is not due to the fault of the individual.

39 (iii) "Loss of minimum essential coverage" does not include  
40 loss of that coverage due to the individual's failure to pay



1 premiums on a timely basis or situations allowing for a rescission,  
2 subject to clause (ii) and Sections 1389.7 and 1389.21.

3 (B) He or she gains a dependent or becomes a dependent.

4 (C) He or she is mandated to be covered as a dependent pursuant  
5 to a valid state or federal court order.

6 (D) He or she has been released from incarceration.

7 (E) His or her health coverage issuer substantially violated a  
8 material provision of the health coverage contract.

9 (F) He or she gains access to new health benefit plans as a result  
10 of a permanent move.

11 (G) He or she was receiving services from a contracting provider  
12 under another health benefit plan, as defined in Section 1399.845  
13 of this code or Section 10965 of the Insurance Code, for one of  
14 the conditions described in subdivision (c) of Section 1373.96 and  
15 that provider is no longer participating in the health benefit plan.

16 (H) He or she demonstrates to the Exchange, with respect to  
17 health benefit plans offered through the Exchange, or to the  
18 department, with respect to health benefit plans offered outside  
19 the Exchange, that he or she did not enroll in a health benefit plan  
20 during the immediately preceding enrollment period available to  
21 the individual because he or she was misinformed that he or she  
22 was covered under minimum essential coverage.

23 (I) He or she is a member of the reserve forces of the United  
24 States military returning from active duty or a member of the  
25 California National Guard returning from active duty service under  
26 Title 32 of the United States Code.

27 (J) With respect to individual health benefit plans offered  
28 through the Exchange, in addition to the triggering events listed  
29 in this paragraph, any other events listed in Section 155.420(d) of  
30 Title 45 of the Code of Federal Regulations.

31 (2) With respect to individual health benefit plans offered  
32 outside the Exchange, an individual shall have 60 days from the  
33 date of a triggering event identified in paragraph (1) to apply for  
34 coverage from a health care service plan subject to this section.  
35 With respect to individual health benefit plans offered through the  
36 Exchange, an individual shall have 60 days from the date of a  
37 triggering event identified in paragraph (1) to select a plan offered  
38 through the Exchange, unless a longer period is provided in Part  
39 155 (commencing with Section 155.10) of Subchapter B of Subtitle  
40 A of Title 45 of the Code of Federal Regulations.

(e) With respect to individual health benefit plans offered through the Exchange, the effective date of coverage required pursuant to this section shall be consistent with the dates specified in Section 155.410 or 155.420 of Title 45 of the Code of Federal Regulations, as applicable. A dependent who is a registered domestic partner pursuant to Section 297 of the Family Code shall have the same effective date of coverage as a spouse.

(f) With respect to individual health benefit plans offered outside the Exchange, the following provisions shall apply:

(1) After an individual submits a completed application form for a plan contract, the health care service plan shall, within 30 days, notify the individual of the individual's actual premium charges for that plan established in accordance with Section 1399.855. The individual shall have 30 days in which to exercise the right to buy coverage at the quoted premium charges.

(2) With respect to an individual health benefit plan for which an individual applies during the initial open enrollment period described in subdivision (c), when the subscriber submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, by December 15, 2013, coverage under the individual health benefit plan shall become effective no later than January 1, 2014. When that payment is delivered or postmarked within the first 15 days of any subsequent month, coverage shall become effective no later than the first day of the following month. When that payment is delivered or postmarked between December 16, 2013, and December 31, 2013, inclusive, or after the 15th day of any subsequent month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(3) With respect to an individual health benefit plan for which an individual applies during the annual open enrollment period described in subdivision (c), when the individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs later, by December 15, coverage shall become effective as of the following January 1. When that payment is delivered or postmarked within the first 15 days of any subsequent month, coverage shall become effective no later than the first day of the following month. When that payment is delivered or postmarked between December 16

1 and December 31, inclusive, or after the 15th day of any subsequent  
2 month, coverage shall become effective no later than the first day  
3 of the second month following delivery or postmark of the  
4 payment.

5 (4) With respect to an individual health benefit plan for which  
6 an individual applies during a special enrollment period described  
7 in subdivision (d), the following provisions shall apply:

8 (A) When the individual submits a premium payment, based  
9 on the quoted premium charges, and that payment is delivered or  
10 postmarked, whichever occurs earlier, within the first 15 days of  
11 the month, coverage under the plan shall become effective no later  
12 than the first day of the following month. When the premium  
13 payment is neither delivered nor postmarked until after the 15th  
14 day of the month, coverage shall become effective no later than  
15 the first day of the second month following delivery or postmark  
16 of the payment.

17 (B) Notwithstanding subparagraph (A), in the case of a birth,  
18 adoption, or placement for adoption, the coverage shall be effective  
19 on the date of birth, adoption, or placement for adoption.

20 (C) Notwithstanding subparagraph (A), in the case of marriage  
21 or becoming a registered domestic partner or in the case where a  
22 qualified individual loses minimum essential coverage, the  
23 coverage effective date shall be the first day of the month following  
24 the date the plan receives the request for special enrollment.

25 (g) (1) A health care service plan shall not establish rules for  
26 eligibility, including continued eligibility, of any individual to  
27 enroll under the terms of an individual health benefit plan based  
28 on any of the following factors:

29 (A) Health status.

30 (B) Medical condition, including physical and mental illnesses.

31 (C) Claims experience.

32 (D) Receipt of health care.

33 (E) Medical history.

34 (F) Genetic information.

35 (G) Evidence of insurability, including conditions arising out  
36 of acts of domestic violence.

37 (H) Disability.

38 (I) Any other health status-related factor as determined by any  
39 federal regulations, rules, or guidance issued pursuant to Section  
40 2705 of the federal Public Health Service Act.

(2) Notwithstanding Section 1389.1, a health care service plan shall not require an individual applicant or his or her dependent to fill out a health assessment or medical questionnaire prior to enrollment under an individual health benefit plan. A health care service plan shall not acquire or request information that relates to a health status-related factor from the applicant or his or her dependent or any other source prior to enrollment of the individual.

(h) (1) A health care service plan shall consider as a single risk pool for rating purposes in the individual market the claims experience of *all insureds and* all enrollees in all nongrandfathered individual health benefit plans offered by that health care service plan in this state ~~and all insureds in all nongrandfathered individual health benefit plans, as defined in Section 10965 of the Insurance Code, offered in this state by a health insurer that is a corporate affiliate, subsidiary, or parent of the plan, state, whether offered as health care service plan contracts or individual health insurance policies,~~ including those insureds and enrollees who enroll in individual coverage through the Exchange and insureds and enrollees who enroll in individual coverage outside of the Exchange. Student health insurance coverage, as that coverage is defined in Section 147.145(a) of Title 45 of the Code of Federal Regulations, shall not be included in a health care service plan's single risk pool for individual coverage.

(2) Each calendar year, a health care service plan shall establish an index rate for the individual market in the state based on the total combined claims costs for providing essential health benefits, as defined pursuant to Section 1302 of PPACA, within the single risk pool required under paragraph (1). The index rate shall be adjusted on a marketwide basis based on the total expected marketwide payments and charges under the risk adjustment and reinsurance programs established for the state pursuant to Sections 1343 and 1341 of PPACA and Exchange user fees, as described in subdivision (d) of Section 156.80 of Title 45 of the Code of Federal Regulations. The premium rate for all of the health benefit plans in the individual market within the single risk pool required under paragraph (1) shall use the applicable index rate, ~~as adjusted for total expected marketwide payments and charges under the risk adjustment and reinsurance programs established for the state pursuant to Sections 1343 and 1341 of PPACA, marketwide~~

1 *adjusted index rate*, subject only to the adjustments permitted  
2 under paragraph (3).

3 (3) A health care service plan may vary premium rates for a  
4 particular health benefit plan from its index rate based only on the  
5 following actuarially justified plan-specific factors:

6 (A) The actuarial value and cost-sharing design of the health  
7 benefit plan.

8 (B) The health benefit plan's provider network, delivery system  
9 characteristics, and utilization management practices.

10 (C) The benefits provided under the health benefit plan that are  
11 in addition to the essential health benefits, as defined pursuant to  
12 Section 1302 of PPACA and Section 1367.005. These additional  
13 benefits shall be pooled with similar benefits within the single risk  
14 pool required under paragraph (1) and the claims experience from  
15 those benefits shall be utilized to determine rate variations for  
16 plans that offer those benefits in addition to essential health  
17 benefits.

18 (D) With respect to catastrophic plans, as described in subsection  
19 (e) of Section 1302 of PPACA, the expected impact of the specific  
20 eligibility categories for those plans.

21 (E) Administrative costs, excluding user fees required by the  
22 Exchange.

23 (i) This section shall only apply with respect to individual health  
24 benefit plans for policy years on or after January 1, 2014.

25 (j) This section shall not apply to a grandfathered health plan.

26 (k) If Section 5000A of the Internal Revenue Code, as added  
27 by Section 1501 of PPACA, is repealed or amended to no longer  
28 apply to the individual market, as defined in Section 2791 of the  
29 federal Public Health Service Act (42 U.S.C. Sec. 300gg-91),  
30 subdivisions (a), (b), and (g) shall become inoperative 12 months  
31 after that repeal or amendment.

32 SEC. 15. Section 10112.27 of the Insurance Code is amended  
33 to read:

34 10112.27. (a) An individual or small group health insurance  
35 policy issued, amended, or renewed on or after January 1, 2014,  
36 shall, at a minimum, include coverage for essential health benefits  
37 pursuant to PPACA and as outlined in this section. This section  
38 shall exclusively govern what benefits a health insurer must cover  
39 as essential health benefits. For purposes of this section, "essential  
40 health benefits" means all of the following:

(1) Health benefits within the categories identified in Section 1302(b) of PPACA: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care.

(2) (A) The health benefits covered by the Kaiser Foundation Health Plan Small Group HMO 30 plan (federal health product identification number 40513CA035) as this plan was offered during the first quarter of 2012, as follows, regardless of whether the benefits are specifically referenced in the plan contract or evidence of coverage for that plan:

(i) Medically necessary basic health care services, as defined in subdivision (b) of Section 1345 of the Health and Safety Code and in Section 1300.67 of Title 28 of the California Code of Regulations.

(ii) The health benefits mandated to be covered by the plan pursuant to statutes enacted before December 31, 2011, as described in the following sections of the Health and Safety Code: Sections 1367.002, 1367.06, and 1367.35 (preventive services for children); Section 1367.25 (prescription drug coverage for contraceptives); Section 1367.45 (AIDS vaccine); Section 1367.46 (HIV testing); Section 1367.51 (diabetes); Section 1367.54 (alpha fetoprotein testing); Section 1367.6 (breast cancer screening); Section 1367.61 (prosthetics for laryngectomy); Section 1367.62 (maternity hospital stay); Section 1367.63 (reconstructive surgery); Section 1367.635 (mastectomies); Section 1367.64 (prostate cancer); Section 1367.65 (mammography); Section 1367.66 (cervical cancer); Section 1367.665 (cancer screening tests); Section 1367.67 (osteoporosis); Section 1367.68 (surgical procedures for jaw bones); Section 1367.71 (anesthesia for dental); Section 1367.9 (conditions attributable to diethylstilbestrol); Section 1368.2 (hospice care); Section 1370.6 (cancer clinical trials); Section 1371.5 (emergency response ambulance or ambulance transport services); subdivision (b) of Section 1373 (sterilization operations or procedures); Section 1373.4 (inpatient hospital and ambulatory maternity); Section 1374.56 (phenylketonuria); Section 1374.17 (organ transplants for HIV);

1 Section 1374.72 (mental health parity); and Section 1374.73  
2 (autism/behavioral health treatment).

3 (iii) Any other benefits mandated to be covered by the plan  
4 pursuant to statutes enacted before December 31, 2011, as  
5 described in those statutes.

6 (iv) The health benefits covered by the plan that are not  
7 otherwise required to be covered under Chapter 2.2 (commencing  
8 with Section 1340) of Division 2 of the Health and Safety Code,  
9 to the extent otherwise required pursuant to Sections 1367.18,  
10 1367.21, 1367.215, 1367.22, 1367.24, and 1367.25 of the Health  
11 and Safety Code, and Section 1300.67.24 of Title 28 of the  
12 California Code of Regulations.

13 (v) Any other health benefits covered by the plan that are not  
14 otherwise required to be covered under Chapter 2.2 (commencing  
15 with Section 1340) of Division 2 of the Health and Safety Code.

16 (B) Where there are any conflicts or omissions in the plan  
17 identified in subparagraph (A) as compared with the requirements  
18 for health benefits under Chapter 2.2 (commencing with Section  
19 1340) of Division 2 of the Health and Safety Code that were  
20 enacted prior to December 31, 2011, the requirements of Chapter  
21 2.2 (commencing with Section 1340) of Division 2 of the Health  
22 and Safety Code shall be controlling, except as otherwise specified  
23 in this section.

24 (C) Notwithstanding subparagraph (B) or any other provision  
25 of this section, the home health services benefits covered under  
26 the plan identified in subparagraph (A) shall be deemed to not be  
27 in conflict with Chapter 2.2 (commencing with Section 1340) of  
28 Division 2 of the Health and Safety Code.

29 (D) For purposes of this section, the Paul Wellstone and Pete  
30 Domenici Mental Health Parity and Addiction Equity Act of 2008  
31 (Public Law 110-343) shall apply to a policy subject to this section.  
32 Coverage of mental health and substance use disorder services  
33 pursuant to this paragraph, along with any scope and duration  
34 limits imposed on the benefits, shall be in compliance with the  
35 Paul Wellstone and Pete Domenici Mental Health Parity and  
36 Addiction Equity Act of 2008 (Public Law 110-343), and all rules,  
37 regulations, and guidance issued pursuant to Section 2726 of the  
38 federal Public Health Service Act (42 U.S.C. Sec. 300gg-26).

39 (3) With respect to habilitative services, in addition to any  
40 habilitative services identified in paragraph (2), coverage shall

1 also be provided as required by federal rules, regulations, or  
2 guidance issued pursuant to Section 1302(b) of PPACA.  
3 Habilitative services shall be covered under the same terms and  
4 conditions applied to rehabilitative services under the policy.

5 (4) With respect to pediatric vision care, the same health benefits  
6 for pediatric vision care covered under the Federal Employees  
7 Dental and Vision Insurance Program vision plan with the largest  
8 national enrollment as of the first quarter of 2012. The pediatric  
9 vision care services covered pursuant to this paragraph shall be in  
10 addition to, and shall not replace, any vision services covered under  
11 the plan identified in paragraph (2).

12 (5) With respect to pediatric oral care, the same health benefits  
13 for pediatric oral care covered under the dental plan available to  
14 subscribers of the Healthy Families Program in 2011–12, including  
15 the provision of medically necessary orthodontic care provided  
16 pursuant to the federal Children’s Health Insurance Program  
17 Reauthorization Act of 2009. The pediatric oral care benefits  
18 covered pursuant to this paragraph shall be in addition to, and shall  
19 not replace, any dental or orthodontic services covered under the  
20 plan identified in paragraph (2).

21 (b) Treatment limitations imposed on health benefits described  
22 in this section shall be no greater than the treatment limitations  
23 imposed by the corresponding plans identified in subdivision (a),  
24 subject to the requirements set forth in paragraph (2) of subdivision  
25 (a).

26 (c) Except as provided in subdivision (d), nothing in this section  
27 shall be construed to permit a health insurer to make substitutions  
28 for the benefits required to be covered under this section, regardless  
29 of whether those substitutions are actuarially equivalent.

30 (d) To the extent permitted under Section 1302 of PPACA and  
31 any rules, regulations, or guidance issued pursuant to that section,  
32 and to the extent that substitution would not create an obligation  
33 for the state to defray costs for any individual, an insurer may  
34 substitute its prescription drug formulary for the formulary  
35 provided under the plan identified in subdivision (a) as long as the  
36 coverage for prescription drugs complies with the sections  
37 referenced in clauses (ii) and (iv) of subparagraph (A) of paragraph  
38 (2) of subdivision (a) that apply to prescription drugs.

39 (e) No health insurer, or its agent, producer, or representative,  
40 shall issue, deliver, renew, offer, market, represent, or sell any



1 product, policy, or discount arrangement as compliant with the  
2 essential health benefits requirement in federal law, unless it meets  
3 all of the requirements of this section. This subdivision shall be  
4 enforced in the same manner as Section 790.03, including through  
5 the means specified in Sections 790.035 and 790.05.

6 (f) This section shall apply regardless of whether the policy is  
7 offered inside or outside the California Health Benefit Exchange  
8 created by Section 100500 of the Government Code.

9 (g) Nothing in this section shall be construed to exempt a health  
10 insurer or a health insurance policy from meeting other applicable  
11 requirements of law.

12 (h) This section shall not be construed to prohibit a policy from  
13 covering additional benefits, including, but not limited to, spiritual  
14 care services that are tax deductible under Section 213 of the  
15 Internal Revenue Code.

16 (i) Subdivision (a) shall not apply to any of the following:

17 (1) A policy that provides excepted benefits as described in  
18 Sections 2722 and 2791 of the federal Public Health Service Act  
19 (42 U.S.C. Sec. 300gg-21; 42 U.S.C. Sec. 300gg-91).

20 (2) A policy that qualifies as a grandfathered health plan under  
21 Section 1251 of PPACA or any binding rules, regulation, or  
22 guidance issued pursuant to that section.

23 (j) Nothing in this section shall be implemented in a manner  
24 that conflicts with a requirement of PPACA.

25 (k) This section shall be implemented only to the extent essential  
26 health benefits are required pursuant to PPACA.

27 (l) An essential health benefit is required to be provided under  
28 this section only to the extent that federal law does not require the  
29 state to defray the costs of the benefit.

30 (m) Nothing in this section shall obligate the state to incur costs  
31 for the coverage of benefits that are not essential health benefits  
32 as defined in this section.

33 (n) An insurer is not required to cover, under this section,  
34 changes to health benefits that are the result of statutes enacted on  
35 or after December 31, 2011.

36 (o) (1) The commissioner may adopt emergency regulations  
37 implementing this section. The commissioner may, on a one-time  
38 basis, readopt any emergency regulation authorized by this section  
39 that is the same as, or substantially equivalent to, an emergency  
40 regulation previously adopted under this section.

(2) The initial adoption of emergency regulations implementing this section and the readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The initial emergency regulations and the readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

(3) The commissioner shall consult with the Director of the Department of Managed Health Care to ensure consistency and uniformity in the development of regulations under this subdivision.

(4) This subdivision shall become inoperative on March 1, 2016.

(p) Nothing in this section shall impose on health insurance policies the cost sharing or network limitations of the plans identified in subdivision (a) except to the extent otherwise required to comply with provisions of this code, including this section, and as otherwise applicable to all health insurance policies offered to individuals and small groups.

(q) For purposes of this section, the following definitions shall apply:

(1) “Habilitative services” means medically necessary health care services and health care devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual’s environment. Examples of health care services that are not habilitative services include, but are not limited to, respite care, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind, including, but not limited to, vocational training. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the policy.

(2) (A) “Health benefits,” unless otherwise required to be defined pursuant to federal rules, regulations, or guidance issued pursuant to Section 1302(b) of PPACA, means health care items or services for the diagnosis, cure, mitigation, treatment, or

1 prevention of illness, injury, disease, or a health condition,  
2 including a behavioral health condition.

3 (B) “Health benefits” does not mean any cost-sharing  
4 requirements such as copayments, coinsurance, or deductibles.

5 (3) “PPACA” means the federal Patient Protection and  
6 Affordable Care Act (Public Law 111-148), as amended by the  
7 federal Health Care and Education Reconciliation Act of 2010  
8 (Public Law 111-152), and any rules, regulations, or guidance  
9 issued thereunder.

10 (4) “Small group health insurance policy” means a group health  
11 insurance policy issued to a small employer, as defined in Section  
12 10753.

13 SEC. 16. Section 10112.28 of the Insurance Code is amended  
14 to read:

15 10112.28. (a) This section shall apply to nongrandfathered  
16 individual and group health insurance policies that provide  
17 coverage for essential health benefits, as defined in Section  
18 10112.27, and that are issued, amended, or renewed on or after  
19 January 1, 2015.

20 (b) (1) For nongrandfathered health insurance policies in the  
21 individual or small group markets, a health insurance policy, except  
22 a specialized health insurance policy, that is issued, amended, or  
23 renewed on or after January 1, 2015, shall provide for a limit on  
24 annual out-of-pocket expenses for all covered benefits that meet  
25 the definition of essential health benefits in Section 10112.27,  
26 including out-of-network emergency care.

27 (2) For nongrandfathered health insurance policies in the large  
28 group market, a health insurance policy, except a specialized health  
29 insurance policy, that is issued, amended, or renewed on or after  
30 January 1, 2015, shall provide for a limit on annual out-of-pocket  
31 expenses for covered benefits, including out-of-network emergency  
32 care. This limit shall apply only to essential health benefits, as  
33 defined in Section 10112.27, that are covered under the policy to  
34 the extent that this provision does not conflict with federal law or  
35 guidance on out-of-pocket maximums for nongrandfathered health  
36 insurance policies in the large group market.

37 (c) (1) The limit described in subdivision (b) shall not exceed  
38 the limit described in Section 1302(c) of PPACA and any  
39 subsequent rules, regulations, or guidance issued under that section.

(2) The limit described in subdivision (b) shall result in a total maximum out-of-pocket limit for all covered essential health benefits that shall equal the dollar amounts in effect under Section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 with the dollar amounts adjusted as specified in Section 1302(c)(1)(B) of PPACA.

(d) Nothing in this section shall be construed to affect the reduction in cost sharing for eligible insureds described in Section 1402 of PPACA and any subsequent rules, regulations, or guidance issued under that section.

(e) If an essential health benefit is offered or provided by a specialized health insurance policy, the total annual out-of-pocket maximum for all covered essential benefits shall not exceed the limit in subdivision (b). This section shall not apply to a specialized health insurance policy that does not offer an essential health benefit as defined in Section 10112.27.

(f) The maximum out-of-pocket limit shall apply to any copayment, coinsurance, deductible, and any other form of cost sharing for all covered benefits that meet the definition of essential health benefits, as defined in Section 10112.27.

(g) For nongrandfathered health insurance policies in the group market, “policy year” has the meaning set forth in Section 144.103 of Title 45 of the Code of Federal Regulations. For nongrandfathered health insurance policies sold in the individual market, “policy year” means the calendar year.

(h) “PPACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

SEC. 17. Section 10112.3 of the Insurance Code, as amended by Section 11 of Chapter 5 of the First Extraordinary Session of the Statutes of 2013, is amended to read:

10112.3. (a) For purposes of this section, the following definitions shall apply:

(1) “Exchange” means the California Health Benefit Exchange established in Title 22 (commencing with Section 100500) of the Government Code.

(2) “Federal act” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the

1 federal Health Care and Education Reconciliation Act of 2010  
2 (Public Law 111-152), and any amendments to, or regulations or  
3 guidance issued under, those acts.

4 (3) “Qualified health plan” has the same meaning as that term  
5 is defined in Section 1301 of the federal act.

6 (4) “Small employer” has the same meaning as that term is  
7 defined in Section 10753.

8 (b) (1) Health insurers participating in the individual market  
9 of the Exchange shall fairly and affirmatively offer, market, and  
10 sell in the individual market of the Exchange at least one product  
11 within each of the five levels of coverage contained in subsections  
12 (d) and (e) of Section 1302 of the federal act. Health insurers  
13 participating in the Small Business Health Options Program (SHOP  
14 Program) of the Exchange, established pursuant to subdivision  
15 (m) of Section 100504 of the Government Code, shall fairly and  
16 affirmatively offer, market, and sell in the SHOP Program at least  
17 one product within each of the four levels of coverage contained  
18 in subsection (d) of Section 1302 of the federal act.

19 (2) The board established under Section 100500 of the  
20 Government Code may require insurers to sell additional products  
21 within each of the levels of coverage identified in paragraph (1).

22 (3) This subdivision shall not apply to an insurer that solely  
23 offers supplemental coverage in the Exchange under paragraph  
24 (10) of subdivision (a) of Section 100504 of the Government Code.  
25 This subdivision shall not apply to a bridge plan product of a  
26 Medi-Cal managed care plan that contracts with the State  
27 Department of Health Care Services pursuant to Section 14005.70  
28 of the Welfare and Institutions Code and that meets the  
29 requirements of Section 100504.5 of the Government Code, to the  
30 extent approved by the appropriate federal agency.

31 (c) (1) Health insurers participating in the Exchange that sell  
32 any products outside the Exchange shall do both of the following:

33 (A) Fairly and affirmatively offer, market, and sell all products  
34 made available to individuals in the Exchange to individuals  
35 purchasing coverage outside the Exchange.

36 (B) Fairly and affirmatively offer, market, and sell all products  
37 made available to small employers in the Exchange to small  
38 employers purchasing coverage outside the Exchange.

39 (2) For purposes of this subdivision, “product” does not include  
40 contracts entered into pursuant to Part 6.2 (commencing with

1 Section 12693) of Division 2 between the Managed Risk Medical  
2 Insurance Board and health insurers for enrolled Healthy Families  
3 beneficiaries or to contracts entered into pursuant to Chapter 7  
4 (commencing with Section 14000) of, or Chapter 8 (commencing  
5 with Section 14200) of, Part 3 of Division 9 of the Welfare and  
6 Institutions Code between the State Department of Health Care  
7 Services and health insurers for enrolled Medi-Cal beneficiaries  
8 or for contracts with bridge plan products that meet the  
9 requirements of Section 100504.5 of the Government Code.

10 (d) (1) Commencing January 1, 2014, a health insurer shall,  
11 with respect to individual policies that cover hospital, medical, or  
12 surgical benefits, only sell the five levels of coverage contained  
13 in subsections (d) and (e) of Section 1302 of the federal act, except  
14 that a health insurer that does not participate in the Exchange shall,  
15 with respect to individual policies that cover hospital, medical, or  
16 surgical benefits, only sell the four levels of coverage contained  
17 in subsection (d) of Section 1302 of the federal act.

18 (2) Commencing January 1, 2014, a health insurer shall, with  
19 respect to small employer policies that cover hospital, medical, or  
20 surgical expenses, only sell the four levels of coverage contained  
21 in subsection (d) of Section 1302 of the federal act.

22 (e) Commencing January 1, 2014, a health insurer that does not  
23 participate in the Exchange shall, with respect to individual or  
24 small employer policies that cover hospital, medical, or surgical  
25 expenses, offer at least one standardized product that has been  
26 designated by the Exchange in each of the four levels of coverage  
27 contained in subsection (d) of Section 1302 of the federal act. This  
28 subdivision shall only apply if the board of the Exchange exercises  
29 its authority under subdivision (c) of Section 100504 of the  
30 Government Code. Nothing in this subdivision shall require an  
31 insurer that does not participate in the Exchange to offer  
32 standardized products in the small employer market if the insurer  
33 only sells products in the individual market. Nothing in this  
34 subdivision shall require an insurer that does not participate in the  
35 Exchange to offer standardized products in the individual market  
36 if the insurer only sells products in the small employer market.  
37 This subdivision shall not be construed to prohibit the insurer from  
38 offering other products provided that it complies with subdivision  
39 (d).

1 (f) For purposes of this section, a bridge plan product shall mean  
2 an individual health benefit plan, as defined in subdivision (a) of  
3 Section 10198.6 that is offered by a health insurer that contracts  
4 with the Exchange pursuant to Section 100504.5 of the Government  
5 Code.

6 (g) This section shall become inoperative on the October 1 that  
7 is five years after the date that federal approval of the bridge plan  
8 option occurs, and, as of the second January 1 thereafter, is  
9 repealed, unless a later enacted statute that is enacted before that  
10 date deletes or extends the dates on which it becomes inoperative  
11 and is repealed.

12 SEC. 18. Section 10112.3 of the Insurance Code, as added by  
13 Section 12 of Chapter 5 of the First Extraordinary Session of the  
14 Statutes of 2013, is amended to read:

15 10112.3. (a) For purposes of this section, the following  
16 definitions shall apply:

17 (1) “Exchange” means the California Health Benefit Exchange  
18 established in Title 22 (commencing with Section 100500) of the  
19 Government Code.

20 (2) “Federal act” means the federal Patient Protection and  
21 Affordable Care Act (Public Law 111-148), as amended by the  
22 federal Health Care and Education Reconciliation Act of 2010  
23 (Public Law 111-152), and any amendments to, or regulations or  
24 guidance issued under, those acts.

25 (3) “Qualified health plan” has the same meaning as that term  
26 is defined in Section 1301 of the federal act.

27 (4) “Small employer” has the same meaning as that term is  
28 defined in Section 10753.

29 (b) (1) Health insurers participating in the individual market  
30 of the Exchange shall fairly and affirmatively offer, market, and  
31 sell in the individual market of the Exchange at least one product  
32 within each of the five levels of coverage contained in subsections  
33 (d) and (e) of Section 1302 of the federal act. Health insurers  
34 participating in the Small Business Health Options Program (SHOP  
35 Program) of the Exchange, established pursuant to subdivision  
36 (m) of Section 100504 of the Government Code, shall fairly and  
37 affirmatively offer, market, and sell in the SHOP Program at least  
38 one product within each of the four levels of coverage contained  
39 in subsection (d) of Section 1302 of the federal act.

(2) The board established under Section 100500 of the Government Code may require insurers to sell additional products within each of the levels of coverage identified in paragraph (1).

(3) This subdivision shall not apply to an insurer that solely offers supplemental coverage in the Exchange under paragraph (10) of subdivision (a) of Section 100504 of the Government Code.

(c) (1) Health insurers participating in the Exchange that sell any products outside the Exchange shall do both of the following:

(A) Fairly and affirmatively offer, market, and sell all products made available to individuals in the Exchange to individuals purchasing coverage outside the Exchange.

(B) Fairly and affirmatively offer, market, and sell all products made available to small employers in the Exchange to small employers purchasing coverage outside the Exchange.

(2) For purposes of this subdivision, “product” does not include contracts entered into pursuant to Part 6.2 (commencing with Section 12693) of Division 2 between the Managed Risk Medical Insurance Board and health insurers for enrolled Healthy Families beneficiaries or to contracts entered into pursuant to Chapter 7 (commencing with Section 14000) of, or Chapter 8 (commencing with Section 14200) of, Part 3 of Division 9 of the Welfare and Institutions Code between the State Department of Health Care Services and health insurers for enrolled Medi-Cal beneficiaries.

(d) (1) Commencing January 1, 2014, a health insurer shall, with respect to individual policies that cover hospital, medical, or surgical benefits, only sell the five levels of coverage contained in subsections (d) and (e) of Section 1302 of the federal act, except that a health insurer that does not participate in the Exchange shall, with respect to individual policies that cover hospital, medical, or surgical benefits, only sell the four levels of coverage contained in subsection (d) of Section 1302 of the federal act.

(2) Commencing January 1, 2014, a health insurer shall, with respect to small employer policies that cover hospital, medical, or surgical expenses, only sell the four levels of coverage contained in subsection (d) of Section 1302 of the federal act.

(e) Commencing January 1, 2014, a health insurer that does not participate in the Exchange shall, with respect to individual or small employer policies that cover hospital, medical, or surgical expenses, offer at least one standardized product that has been designated by the Exchange in each of the four levels of coverage



contained in subsection (d) of Section 1302 of the federal act. This subdivision shall only apply if the board of the Exchange exercises its authority under subdivision (c) of Section 100504 of the Government Code. Nothing in this subdivision shall require an insurer that does not participate in the Exchange to offer standardized products in the small employer market if the insurer only sells products in the individual market. Nothing in this subdivision shall require an insurer that does not participate in the Exchange to offer standardized products in the individual market if the insurer only sells products in the small employer market. This subdivision shall not be construed to prohibit the insurer from offering other products provided that it complies with subdivision (d).

(f) This section shall become operative only if Section 11 of the act that added this section becomes inoperative pursuant to subdivision (g) of that Section 11.

SEC. 19. Section 10113.9 of the Insurance Code is amended to read:

10113.9. (a) This section shall not apply to short-term limited duration health insurance, vision-only, dental-only, or CHAMPUS-supplement insurance, or to hospital indemnity, hospital-only, accident-only, or specified disease insurance that does not pay benefits on a fixed benefit, cash payment only basis.

(b) (1) No change in the premium rate or coverage for an individual health insurance policy shall become effective unless the insurer has delivered a written notice of the change at least 15 days prior to the start of the annual enrollment period applicable to the policy or 60 days prior to the effective date of the policy renewal, whichever occurs earlier in the calendar year.

(2) The written notice required pursuant to paragraph (1) shall be delivered to the individual policyholder at his or her last address known to the insurer. The notice shall state in italics and in 12-point type the actual dollar amount of the premium increase and the specific percentage by which the current premium will be increased. The notice shall describe in plain, understandable English any changes in the policy or any changes in benefits, including a reduction in benefits or changes to waivers, exclusions, or conditions, and highlight this information by printing it in italics. The notice shall specify in a minimum of 10-point bold typeface,

1 the reason for a premium rate change or a change in coverage or  
2 benefits.

3 *(c) If an insurer rejects a dependent of a policyholder applying*  
4 *to be added to the policyholder's individual grandfathered health*  
5 *plan, rejects an applicant for a Medicare supplement policy due*  
6 *to the applicant having end-stage renal disease, or offers an*  
7 *individual grandfathered health plan to an applicant at a rate that*  
8 *is higher than the standard rate, the insurer shall inform the*  
9 *applicant about the California Major Risk Medical Insurance*  
10 *Program (MRMIP) (Part 6.5 (commencing with Section 12700)*  
11 *of Division 2) and about the new coverage options, and the*  
12 *potential for subsidized coverage, through Covered California.*  
13 *The insurer shall direct persons seeking more information to*  
14 *MRMIP, Covered California, plan or policy representatives,*  
15 *insurance agents, or an entity paid by Covered California to assist*  
16 *with health coverage enrollment, such as a navigator or an assister.*

17 ~~(e)~~

18 *(d) A notice provided pursuant to this section is a private and*  
19 *confidential communication and, at the time of application, the*  
20 *insurer shall give the applicant the opportunity to designate the*  
21 *address for receipt of the written notice in order to protect the*  
22 *confidentiality of any personal or privileged information.*

23 *(e) For purposes of this section, the following definitions shall*  
24 *apply:*

25 *(1) "Covered California" means the California Health Benefit*  
26 *Exchange established pursuant to Section 100500 of the*  
27 *Government Code.*

28 *(2) "Grandfathered health plan" has the same meaning as that*  
29 *term is defined in Section 1251 of PPACA.*

30 *(3) "PPACA" means the federal Patient Protection and*  
31 *Affordable Care Act (Public Law 111-148), as amended by the*  
32 *federal Health Care and Education Reconciliation Act of 2010*  
33 *(Public Law 111-152), and any rules, regulations, or guidance*  
34 *issued pursuant to that law.*

35 SEC. 20. Section 10181.3 of the Insurance Code is amended  
36 to read:

37 10181.3. (a) All health insurers shall file with the department  
38 all required rate information for individual and small group health  
39 insurance policies at least 60 days prior to implementing any rate  
40 change.

1 (b) An insurer shall disclose to the department all of the  
2 following for each individual and small group rate filing:

- 3 (1) Company name and contact information.
- 4 (2) Number of policy forms covered by the filing.
- 5 (3) Policy form numbers covered by the filing.
- 6 (4) Product type, such as indemnity or preferred provider  
7 organization.
- 8 (5) Segment type.
- 9 (6) Type of insurer involved, such as for profit or not for profit.
- 10 (7) Whether the products are opened or closed.
- 11 (8) Enrollment in each policy and rating form.
- 12 (9) Insured months in each policy form.
- 13 (10) Annual rate.
- 14 (11) Total earned premiums in each policy form.
- 15 (12) Total incurred claims in each policy form.
- 16 (13) Average rate change initially requested.
- 17 (14) Review category: initial filing for new product, filing for  
18 existing product, or resubmission.
- 19 (15) Average rate of change.
- 20 (16) Effective date of rate change.
- 21 (17) Number of policyholders or insureds affected by each  
22 policy form.
- 23 (18) The insurer's overall annual medical trend factor  
24 assumptions in each rate filing for all benefits and by aggregate  
25 benefit category, including hospital inpatient, hospital outpatient,  
26 physician services, prescription drugs and other ancillary services,  
27 laboratory, and radiology. An insurer may provide aggregated  
28 additional data that demonstrates or reasonably estimates  
29 year-to-year cost changes in specific benefit categories in the  
30 geographic regions listed in Sections 10753.14 and 10965.9. For  
31 purposes of this paragraph, "major geographic region" shall be  
32 defined by the department and shall include no more than nine  
33 regions.
- 34 (19) The amount of the projected trend attributable to the use  
35 of services, price inflation, or fees and risk for annual policy trends  
36 by aggregate benefit category, such as hospital inpatient, hospital  
37 outpatient, physician services, prescription drugs and other  
38 ancillary services, laboratory, and radiology.
- 39 (20) A comparison of claims cost and rate of changes over time.

1 (21) Any changes in insured cost sharing over the prior year  
2 associated with the submitted rate filing.

3 (22) Any changes in insured benefits over the prior year  
4 associated with the submitted rate filing.

5 (23) The certification described in subdivision (b) of Section  
6 10181.6.

7 (24) Any changes in administrative costs.

8 (25) Any other information required for rate review under  
9 PPACA.

10 (c) An insurer subject to subdivision (a) shall also disclose the  
11 following aggregate data for all rate filings submitted under this  
12 section in the individual and small group health insurance markets:

13 (1) Number and percentage of rate filings reviewed by the  
14 following:

15 (A) Plan year.

16 (B) Segment type.

17 (C) Product type.

18 (D) Number of policyholders.

19 (E) Number of covered lives affected.

20 (2) The insurer's average rate change by the following  
21 categories:

22 (A) Plan year.

23 (B) Segment type.

24 (C) Product type.

25 (3) Any cost containment and quality improvement efforts since  
26 the insurer's last rate filing for the same category of health benefit  
27 plan. To the extent possible, the insurer shall describe any  
28 significant new health care cost containment and quality  
29 improvement efforts and provide an estimate of potential savings  
30 together with an estimated cost or savings for the projection period.

31 (d) The department may require all health insurers to submit all  
32 rate filings to the National Association of Insurance  
33 Commissioners' System for Electronic Rate and Form Filing  
34 (SERFF). Submission of the required rate filings to SERFF shall  
35 be deemed to be filing with the department for purposes of  
36 compliance with this section.

37 (e) A health insurer shall submit any other information required  
38 under PPACA. A health insurer shall also submit any other  
39 information required pursuant to any regulation adopted by the  
40 department to comply with this article.

1 SEC. 21. Section 10181.6 of the Insurance Code is amended  
2 to read:

3 10181.6. (a) A filing submitted under this article shall be  
4 actuarially sound.

5 (b) (1) The health insurer shall contract with an independent  
6 actuary or actuaries consistent with this section.

7 (2) A filing submitted under this article shall include a  
8 certification by an independent actuary or actuarial firm that the  
9 rate change is reasonable or unreasonable and, if unreasonable,  
10 that the justification for the change is based on accurate and sound  
11 actuarial assumptions and methodologies. Unless PPACA requires  
12 a certification of actuarial soundness for each large group health  
13 insurance policy, a filing submitted under Section 10181.4 shall  
14 include a certification by an independent actuary, as described in  
15 this section, that the aggregate or average rate increase is based  
16 on accurate and sound actuarial assumptions and methodologies.

17 (3) The actuary or actuarial firm acting under paragraph (2)  
18 shall not be an affiliate or a subsidiary of, nor in any way owned  
19 or controlled by, a health insurer or a trade association of health  
20 insurers. A board member, director, officer, or employee of the  
21 actuary or actuarial firm shall not serve as a board member,  
22 director, or employee of a health insurer. A board member, director,  
23 or officer of a health insurer or a trade association of health insurers  
24 shall not serve as a board member, director, officer, or employee  
25 of the actuary or actuarial firm.

26 (c) Nothing in this article shall be construed to permit the  
27 commissioner to establish the rates charged insureds and  
28 policyholders for covered health care services.

29 SEC. 22. Section 10181.7 of the Insurance Code is amended  
30 to read:

31 10181.7. (a) Notwithstanding Chapter 3.5 (commencing with  
32 Section 6250) of Division 7 of Title 1 of the Government Code,  
33 all information submitted under this article shall be made publicly  
34 available by the department except as provided in subdivision (b).

35 (b) Any contracted rates between a health insurer and a provider  
36 shall be deemed confidential information that shall not be made  
37 public by the department and are exempt from disclosure under  
38 the California Public Records Act (Chapter 3.5 (commencing with  
39 Section 6250) of Division 7 of Title 1 of the Government Code).

40 The contracted rates between a health insurer and a large group

1 shall be deemed confidential information that shall not be made  
2 public by the department and are exempt from disclosure under  
3 the California Public Records Act (Chapter 3.5 (commencing with  
4 Section 6250) of Division 7 of Title 1 of the Government Code).

5 (c) All information submitted to the department under this article  
6 shall be submitted electronically in order to facilitate review by  
7 the department and the public.

8 (d) In addition, the department and the health insurer shall, at  
9 a minimum, make the following information readily available to  
10 the public on their Internet Web sites, in plain language and in a  
11 manner and format specified by the department, except as provided  
12 in subdivision (b). The information shall be made public for 60  
13 days prior to the implementation of the rate change. The  
14 information shall include:

15 (1) Justifications for any unreasonable rate changes, including  
16 all information and supporting documentation as to why the rate  
17 change is justified.

18 (2) An insurer's overall annual medical trend factor assumptions  
19 in each rate filing for all benefits.

20 (3) An insurer's actual costs, by aggregate benefit category to  
21 include, hospital inpatient, hospital outpatient, physician services,  
22 prescription drugs and other ancillary services, laboratory, and  
23 radiology.

24 (4) The amount of the projected trend attributable to the use of  
25 services, price inflation, or fees and risk for annual policy trends  
26 by aggregate benefit category, such as hospital inpatient, hospital  
27 outpatient, physician services, prescription drugs and other  
28 ancillary services, laboratory, and radiology.

29 SEC. 23. Section 10181.11 of the Insurance Code is amended  
30 to read:

31 10181.11. (a) Whenever it appears to the department that any  
32 person has engaged, or is about to engage, in any act or practice  
33 constituting a violation of this article, including the filing of  
34 inaccurate or unjustified rates or inaccurate or unjustified rate  
35 information, the department may review rate filing to ensure  
36 compliance with the law.

37 (b) The department may review other filings.

38 (c) The department shall accept and post to its Internet Web site  
39 any public comment on a rate change submitted to the department

1 during the 60-day period described in subdivision (d) of Section  
2 10181.7.

3 (d) The department shall report to the Legislature at least  
4 quarterly on all unreasonable rate filings.

5 (e) The department shall post on its Internet Web site any  
6 modifications submitted by the insurer to the proposed rate change,  
7 including any documentation submitted by the insurer supporting  
8 those modifications.

9 (f) If the commissioner makes a decision that an unreasonable  
10 rate change is not justified or that a rate filing contains inaccurate  
11 information, the department shall post that decision on its Internet  
12 Web site.

13 (g) Nothing in this article shall be construed to impair or impede  
14 the department's authority to administer or enforce any other  
15 provision of this code.

16 SEC. 24. Section 10199.1 of the Insurance Code is amended  
17 to read:

18 10199.1. (a) No insurer or nonprofit hospital service plan or  
19 administrator acting on its behalf shall terminate a group master  
20 policy or contract providing hospital, medical, or surgical benefits,  
21 increase premiums or charges therefor, reduce or eliminate benefits  
22 thereunder, or restrict eligibility for coverage thereunder without  
23 providing prior notice of that action. No such action shall become  
24 effective unless written notice of the action was delivered by mail  
25 to the last known address of the appropriate insurance producer  
26 and the appropriate administrator, if any, at least 45 days prior to  
27 the effective date of the action and to the last known address of  
28 the group policyholder or group contractholder at least 60 days  
29 prior to the effective date of the action. If nonemployee certificate  
30 holders or employees of more than one employer are covered under  
31 the policy or contract, written notice shall also be delivered by  
32 mail to the last known address of each nonemployee certificate  
33 holder or affected employer or, if the action does not affect all  
34 employees and dependents of one or more employers, to the last  
35 known address of each affected employee certificate holder, at  
36 least 60 days prior to the effective date of the action.

37 (b) No holder of a master group policy or a master group  
38 nonprofit hospital service plan contract or administrator acting on  
39 its behalf shall terminate the coverage of, increase premiums or  
40 charges for, or reduce or eliminate benefits available to, or restrict

1 eligibility for coverage of a covered person, employer unit, or class  
2 of certificate holders covered under the policy or contract for  
3 hospital, medical, or surgical benefits without first providing prior  
4 notice of the action. No such action shall become effective unless  
5 written notice was delivered by mail to the last known address of  
6 each affected nonemployee certificate holder or employer, or if  
7 the action does not affect all employees and dependents of one or  
8 more employers, to the last known address of each affected  
9 employee certificate holder, at least 60 days prior to the effective  
10 date of the action.

11 (c) A health insurer that declines to offer coverage to or denies  
12 enrollment for a large group applying for coverage shall, at the  
13 time of the denial of coverage, provide the applicant with the  
14 specific reason or reasons for the decision in writing, in clear,  
15 easily understandable language.

16 SEC. 25. Section 10753.05 of the Insurance Code is amended  
17 to read:

18 10753.05. (a) No group or individual policy or contract or  
19 certificate of group insurance or statement of group coverage  
20 providing benefits to employees of small employers as defined in  
21 this chapter shall be issued or delivered by a carrier subject to the  
22 jurisdiction of the commissioner regardless of the situs of the  
23 contract or master policyholder or of the domicile of the carrier  
24 nor, except as otherwise provided in Sections 10270.91 and  
25 10270.92, shall a carrier provide coverage subject to this chapter  
26 until a copy of the form of the policy, contract, certificate, or  
27 statement of coverage is filed with and approved by the  
28 commissioner in accordance with Sections 10290 and 10291, and  
29 the carrier has complied with the requirements of Section 10753.17.

30 (b) (1) On and after October 1, 2013, each carrier shall fairly  
31 and affirmatively offer, market, and sell all of the carrier's health  
32 benefit plans that are sold to, offered through, or sponsored by,  
33 small employers or associations that include small employers for  
34 plan years on or after January 1, 2014, to all small employers in  
35 each geographic region in which the carrier makes coverage  
36 available or provides benefits.

37 (2) A carrier that offers qualified health plans through the  
38 Exchange shall be deemed to be in compliance with paragraph (1)  
39 with respect to health benefit plans offered through the Exchange



1 in those geographic regions in which the carrier offers plans  
2 through the Exchange.

3 (3) A carrier shall provide enrollment periods consistent with  
4 PPACA and described in Section 155.725 of Title 45 of the Code  
5 of Federal Regulations. Commencing January 1, 2014, a carrier  
6 shall provide special enrollment periods consistent with the special  
7 enrollment periods described in Section 10965.3, to the extent  
8 permitted by PPACA, except for the triggering events identified  
9 in paragraphs (d)(3) and (d)(6) of Section 155.420 of Title 45 of  
10 the Code of Federal Regulations with respect to health benefit  
11 plans offered through the Exchange.

12 (4) Nothing in this section shall be construed to require an  
13 association, or a trust established and maintained by an association  
14 to receive a master insurance policy issued by an admitted insurer  
15 and to administer the benefits thereof solely for association  
16 members, to offer, market, or sell a benefit plan design to those  
17 who are not members of the association. However, if the  
18 association markets, offers, or sells a benefit plan design to those  
19 who are not members of the association it is subject to the  
20 requirements of this section. This shall apply to an association that  
21 otherwise meets the requirements of paragraph (8) formed by  
22 merger of two or more associations after January 1, 1992, if the  
23 predecessor organizations had been in active existence on January  
24 1, 1992, and for at least five years prior to that date and met the  
25 requirements of paragraph (5).

26 (5) A carrier which (A) effective January 1, 1992, and at least  
27 20 years prior to that date, markets, offers, or sells benefit plan  
28 designs only to all members of one association and (B) does not  
29 market, offer, or sell any other individual, selected group, or group  
30 policy or contract providing medical, hospital, and surgical benefits  
31 shall not be required to market, offer, or sell to those who are not  
32 members of the association. However, if the carrier markets, offers,  
33 or sells any benefit plan design or any other individual, selected  
34 group, or group policy or contract providing medical, hospital, and  
35 surgical benefits to those who are not members of the association  
36 it is subject to the requirements of this section.

37 (6) Each carrier that sells health benefit plans to members of  
38 one association pursuant to paragraph (5) shall submit an annual  
39 statement to the commissioner which states that the carrier is selling

1 health benefit plans pursuant to paragraph (5) and which, for the  
2 one association, lists all the information required by paragraph (7).

3 (7) Each carrier that sells health benefit plans to members of  
4 any association shall submit an annual statement to the  
5 commissioner which lists each association to which the carrier  
6 sells health benefit plans, the industry or profession which is served  
7 by the association, the association's membership criteria, a list of  
8 officers, the state in which the association is organized, and the  
9 site of its principal office.

10 (8) For purposes of paragraphs (4) and (6), an association is a  
11 nonprofit organization comprised of a group of individuals or  
12 employers who associate based solely on participation in a  
13 specified profession or industry, accepting for membership any  
14 individual or small employer meeting its membership criteria,  
15 which do not condition membership directly or indirectly on the  
16 health or claims history of any person, which uses membership  
17 dues solely for and in consideration of the membership and  
18 membership benefits, except that the amount of the dues shall not  
19 depend on whether the member applies for or purchases insurance  
20 offered by the association, which is organized and maintained in  
21 good faith for purposes unrelated to insurance, which has been in  
22 active existence on January 1, 1992, and at least five years prior  
23 to that date, which has a constitution and bylaws, or other  
24 analogous governing documents which provide for election of the  
25 governing board of the association by its members, which has  
26 contracted with one or more carriers to offer one or more health  
27 benefit plans to all individual members and small employer  
28 members in this state. Health coverage through an association that  
29 is not related to employment shall be considered individual  
30 coverage pursuant to Section 144.102(c) of Title 45 of the Code  
31 of Federal Regulations.

32 (c) On and after October 1, 2013, each carrier shall make  
33 available to each small employer all health benefit plans that the  
34 carrier offers or sells to small employers or to associations that  
35 include small employers for plan years on or after January 1, 2014.  
36 Notwithstanding subdivision (d) of Section 10753, for purposes  
37 of this subdivision, companies that are affiliated companies or that  
38 are eligible to file a consolidated income tax return shall be treated  
39 as one carrier.

40 (d) Each carrier shall do all of the following:

1 (1) Prepare a brochure that summarizes all of its health benefit  
2 plans and make this summary available to small employers, agents,  
3 and brokers upon request. The summary shall include for each  
4 plan information on benefits provided, a generic description of the  
5 manner in which services are provided, such as how access to  
6 providers is limited, benefit limitations, required copayments and  
7 deductibles, an explanation of how creditable coverage is calculated  
8 if a waiting period is imposed, and a telephone number that can  
9 be called for more detailed benefit information. Carriers are  
10 required to keep the information contained in the brochure accurate  
11 and up to date, and, upon updating the brochure, send copies to  
12 agents and brokers representing the carrier. Any entity that provides  
13 administrative services only with regard to a health benefit plan  
14 written or issued by another carrier shall not be required to prepare  
15 a summary brochure which includes that benefit plan.

16 (2) For each health benefit plan, prepare a more detailed  
17 evidence of coverage and make it available to small employers,  
18 agents, and brokers upon request. The evidence of coverage shall  
19 contain all information that a prudent buyer would need to be aware  
20 of in making selections of benefit plan designs. An entity that  
21 provides administrative services only with regard to a health benefit  
22 plan written or issued by another carrier shall not be required to  
23 prepare an evidence of coverage for that health benefit plan.

24 (3) Provide copies of the current summary brochure to all agents  
25 or brokers who represent the carrier and, upon updating the  
26 brochure, send copies of the updated brochure to agents and brokers  
27 representing the carrier for the purpose of selling health benefit  
28 plans.

29 (4) Notwithstanding subdivision (c) of Section 10753, for  
30 purposes of this subdivision, companies that are affiliated  
31 companies or that are eligible to file a consolidated income tax  
32 return shall be treated as one carrier.

33 (e) Every agent or broker representing one or more carriers for  
34 the purpose of selling health benefit plans to small employers shall  
35 do all of the following:

36 (1) When providing information on a health benefit plan to a  
37 small employer but making no specific recommendations on  
38 particular benefit plan designs:

39 (A) Advise the small employer of the carrier's obligation to sell  
40 to any small employer any of the health benefit plans it offers to

1 small employers, consistent with PPACA, and provide them, upon  
2 request, with the actual rates that would be charged to that  
3 employer for a given health benefit plan.

4 (B) Notify the small employer that the agent or broker will  
5 procure rate and benefit information for the small employer on  
6 any health benefit plan offered by a carrier for whom the agent or  
7 broker sells health benefit plans.

8 (C) Notify the small employer that, upon request, the agent or  
9 broker will provide the small employer with the summary brochure  
10 required in paragraph (1) of subdivision (d) for any benefit plan  
11 design offered by a carrier whom the agent or broker represents.

12 (D) Notify the small employer of the availability of coverage  
13 and the availability of tax credits for certain employers consistent  
14 with PPACA and state law, including any rules, regulations, or  
15 guidance issued in connection therewith.

16 (2) When recommending a particular benefit plan design or  
17 designs, advise the small employer that, upon request, the agent  
18 will provide the small employer with the brochure required by  
19 paragraph (1) of subdivision (d) containing the benefit plan design  
20 or designs being recommended by the agent or broker.

21 (3) Prior to filing an application for a small employer for a  
22 particular health benefit plan:

23 (A) For each of the health benefit plans offered by the carrier  
24 whose health benefit plan the agent or broker is presenting, provide  
25 the small employer with the benefit summary required in paragraph  
26 (1) of subdivision (d) and the premium for that particular employer.

27 (B) Notify the small employer that, upon request, the agent or  
28 broker will provide the small employer with an evidence of  
29 coverage brochure for each health benefit plan the carrier offers.

30 (C) Obtain a signed statement from the small employer  
31 acknowledging that the small employer has received the disclosures  
32 required by this paragraph and Section 10753.16.

33 (f) No carrier, agent, or broker shall induce or otherwise  
34 encourage a small employer to separate or otherwise exclude an  
35 eligible employee from a health benefit plan which, in the case of  
36 an eligible employee meeting the definition in paragraph (1) of  
37 subdivision (f) of Section 10753, is provided in connection with  
38 the employee's employment or which, in the case of an eligible  
39 employee as defined in paragraph (2) of subdivision (f) of Section  
40 10753, is provided in connection with a guaranteed association.

1 (g) No carrier shall reject an application from a small employer  
2 for a health benefit plan provided:

3 (1) The small employer as defined by subparagraph (A) of  
4 paragraph (1) of subdivision (q) of Section 10753 offers health  
5 benefits to 100 percent of its eligible employees as defined in  
6 paragraph (1) of subdivision (f) of Section 10753. Employees who  
7 waive coverage on the grounds that they have other group coverage  
8 shall not be counted as eligible employees.

9 (2) The small employer agrees to make the required premium  
10 payments.

11 (h) No carrier or agent or broker shall, directly or indirectly,  
12 engage in the following activities:

13 (1) Encourage or direct small employers to refrain from filing  
14 an application for coverage with a carrier because of the health  
15 status, claims experience, industry, occupation, or geographic  
16 location within the carrier's approved service area of the small  
17 employer or the small employer's employees.

18 (2) Encourage or direct small employers to seek coverage from  
19 another carrier because of the health status, claims experience,  
20 industry, occupation, or geographic location within the carrier's  
21 approved service area of the small employer or the small  
22 employer's employees.

23 (3) Employ marketing practices or benefit designs that will have  
24 the effect of discouraging the enrollment of individuals with  
25 significant health needs or discriminate based on the individual's  
26 race, color, national origin, present or predicted disability, age,  
27 sex, gender identity, sexual orientation, expected length of life,  
28 degree of medical dependency, quality of life, or other health  
29 conditions.

30 This subdivision shall be enforced in the same manner as Section  
31 790.03, including through Sections 790.035 and 790.05.

32 (i) No carrier shall, directly or indirectly, enter into any contract,  
33 agreement, or arrangement with an agent or broker that provides  
34 for or results in the compensation paid to an agent or broker for a  
35 health benefit plan to be varied because of the health status, claims  
36 experience, industry, occupation, or geographic location of the  
37 small employer or the small employer's employees. This  
38 subdivision shall not apply with respect to a compensation  
39 arrangement that provides compensation to an agent or broker on  
40 the basis of percentage of premium, provided that the percentage

1 shall not vary because of the health status, claims experience,  
2 industry, occupation, or geographic area of the small employer.

3 (j) (1) A health benefit plan offered to a small employer, as  
4 defined in Section 1304(b) of PPACA and in Section 10753, shall  
5 not establish rules for eligibility, including continued eligibility,  
6 of an individual, or dependent of an individual, to enroll under the  
7 terms of the plan based on any of the following health status-related  
8 factors:

9 (A) Health status.

10 (B) Medical condition, including physical and mental illnesses.

11 (C) Claims experience.

12 (D) Receipt of health care.

13 (E) Medical history.

14 (F) Genetic information.

15 (G) Evidence of insurability, including conditions arising out  
16 of acts of domestic violence.

17 (H) Disability.

18 (I) Any other health status-related factor as determined by any  
19 federal regulations, rules, or guidance issued pursuant to Section  
20 2705 of the federal Public Health Service Act.

21 (2) Notwithstanding Section 10291.5, a carrier shall not require  
22 an eligible employee or dependent to fill out a health assessment  
23 or medical questionnaire prior to enrollment under a health benefit  
24 plan. A carrier shall not acquire or request information that relates  
25 to a health status-related factor from the applicant or his or her  
26 dependent or any other source prior to enrollment of the individual.

27 (k) (1) A carrier shall consider as a single risk pool for rating  
28 purposes in the small employer market the claims experience of  
29 all insureds in all nongrandfathered small employer health benefit  
30 plans offered by the carrier in this state and all enrollees in all  
31 nongrandfathered small employer health care service plan contracts  
32 subject to Article 3.16 (commencing with Section 1357.500) of  
33 Chapter 2.2 of Division 2 of the Health and Safety Code offered  
34 by a health care service plan licensed under Chapter 2.2  
35 (commencing with Section 1340) of Division 2 of the Health and  
36 Safety Code that is a corporate affiliate, subsidiary, or parent of  
37 the insurer, state, whether offered as health care service plan  
38 contracts or health insurance policies, including those insureds  
39 and enrollees who enroll in coverage through the Exchange and

1 insureds and enrollees ~~who enroll in coverage~~ *covered by the*  
2 *carrier* outside of the Exchange.

3 (2) At least each calendar year, and no more frequently than  
4 each calendar quarter, a carrier shall establish an index rate for the  
5 small employer market in the state based on the total combined  
6 claims costs for providing essential health benefits, as defined  
7 pursuant to Section 1302 of PPACA and Section 10112.27, within  
8 the single risk pool required under paragraph (1). The index rate  
9 shall be adjusted on a marketwide basis based on the total expected  
10 marketwide payments and charges under the risk adjustment and  
11 reinsurance programs established for the state pursuant to Sections  
12 1343 and 1341 of PPACA and Exchange user fees, as described  
13 in subdivision (d) of Section 156.80 of Title 45 of the Code of  
14 Federal Regulations. The premium rate for all of the  
15 nongrandfathered health benefit plans within the single risk pool  
16 required under paragraph (1) shall use the applicable ~~index rate,~~  
17 ~~as adjusted for total expected marketwide payments and charges~~  
18 ~~under the risk adjustment and reinsurance programs established~~  
19 ~~for the state pursuant to Sections 1343 and 1341 of PPACA,~~  
20 *marketwide adjusted index rate*, subject only to the adjustments  
21 permitted under paragraph (3).

22 (3) A carrier may vary premium rates for a particular  
23 nongrandfathered health benefit plan from its index rate based  
24 only on the following actuarially justified plan-specific factors:

25 (A) The actuarial value and cost-sharing design of the health  
26 benefit plan.

27 (B) The health benefit plan's provider network, delivery system  
28 characteristics, and utilization management practices.

29 (C) The benefits provided under the health benefit plan that are  
30 in addition to the essential health benefits, as defined pursuant to  
31 Section 1302 of PPACA. These additional benefits shall be pooled  
32 with similar benefits within the single risk pool required under  
33 paragraph (1) and the claims experience from those benefits shall  
34 be utilized to determine rate variations for health benefit plans that  
35 offer those benefits in addition to essential health benefits.

36 (D) Administrative costs, excluding any user fees required by  
37 the Exchange.

38 (E) With respect to catastrophic plans, as described in subsection  
39 (e) of Section 1302 of PPACA, the expected impact of the specific  
40 eligibility categories for those plans.

1 (l) If a carrier enters into a contract, agreement, or other  
2 arrangement with a third-party administrator or other entity to  
3 provide administrative, marketing, or other services related to the  
4 offering of health benefit plans to small employers in this state,  
5 the third-party administrator shall be subject to this chapter.

6 (m) (1) Except as provided in paragraph (2), this section shall  
7 become inoperative if Section 2702 of the federal Public Health  
8 Service Act (42 U.S.C. Sec. 300gg-1), as added by Section 1201  
9 of PPACA, is repealed, in which case, 12 months after the repeal,  
10 carriers subject to this section shall instead be governed by Section  
11 10705 to the extent permitted by federal law, and all references in  
12 this chapter to this section shall instead refer to Section 10705,  
13 except for purposes of paragraph (2).

14 (2) Paragraph (3) of subdivision (b) of this section shall remain  
15 operative as it relates to health benefit plans offered through the  
16 Exchange.

17 SEC. 26. Section 10965.3 of the Insurance Code is amended  
18 to read:

19 10965.3. (a) (1) On and after October 1, 2013, a health insurer  
20 shall fairly and affirmatively offer, market, and sell all of the  
21 insurer's health benefit plans that are sold in the individual market  
22 for policy years on or after January 1, 2014, to all individuals and  
23 dependents in each service area in which the insurer provides or  
24 arranges for the provision of health care services. A health insurer  
25 shall limit enrollment in individual health benefit plans to open  
26 enrollment periods and special enrollment periods as provided in  
27 subdivisions (c) and (d).

28 (2) A health insurer shall allow the policyholder of an individual  
29 health benefit plan to add a dependent to the policyholder's health  
30 benefit plan at the option of the policyholder, consistent with the  
31 open enrollment, annual enrollment, and special enrollment period  
32 requirements in this section.

33 (b) An individual health benefit plan issued, amended, or  
34 renewed on or after January 1, 2014, shall not impose any  
35 preexisting condition provision upon any individual.

36 (c) (1) A health insurer shall provide an initial open enrollment  
37 period from October 1, 2013, to March 31, 2014, inclusive, and  
38 annual enrollment periods for plan years on or after January 1,  
39 2015, from October 15 to December 7, inclusive, of the preceding  
40 calendar year.



(2) Pursuant to Section 147.104(b)(2) of Title 45 of the Code of Federal Regulations, for individuals enrolled in noncalendar-year individual health plan contracts, a plan shall provide a limited open enrollment period beginning on the date that is 30 calendar days prior to the date the policy year ends in 2014.

(d) (1) Subject to paragraph (2), commencing January 1, 2014, a health insurer shall allow an individual to enroll in or change individual health benefit plans as a result of the following triggering events:

(A) He or she or his or her dependent loses minimum essential coverage. For purposes of this paragraph, the following definitions shall apply:

(i) “Minimum essential coverage” has the same meaning as that term is defined in subsection (f) of Section 5000A of the Internal Revenue Code (26 U.S.C. Sec. 5000A).

(ii) “Loss of minimum essential coverage” includes, but is not limited to, loss of that coverage due to the circumstances described in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of Federal Regulations and the circumstances described in Section 1163 of Title 29 of the United States Code. “Loss of minimum essential coverage” also includes loss of that coverage for a reason that is not due to the fault of the individual.

(iii) “Loss of minimum essential coverage” does not include loss of that coverage due to the individual’s failure to pay premiums on a timely basis or situations allowing for a rescission, subject to clause (ii) and Sections 10119.2 and 10384.17.

(B) He or she gains a dependent or becomes a dependent.

(C) He or she is mandated to be covered as a dependent pursuant to a valid state or federal court order.

(D) He or she has been released from incarceration.

(E) His or her health coverage issuer substantially violated a material provision of the health coverage contract.

(F) He or she gains access to new health benefit plans as a result of a permanent move.

(G) He or she was receiving services from a contracting provider under another health benefit plan, as defined in Section 10965 of this code or Section 1399.845 of the Health and Safety Code for one of the conditions described in subdivision (a) of Section 10133.56 and that provider is no longer participating in the health benefit plan.

1 (H) He or she demonstrates to the Exchange, with respect to  
2 health benefit plans offered through the Exchange, or to the  
3 department, with respect to health benefit plans offered outside  
4 the Exchange, that he or she did not enroll in a health benefit plan  
5 during the immediately preceding enrollment period available to  
6 the individual because he or she was misinformed that he or she  
7 was covered under minimum essential coverage.

8 (I) He or she is a member of the reserve forces of the United  
9 States military returning from active duty or a member of the  
10 California National Guard returning from active duty service under  
11 Title 32 of the United States Code.

12 (J) With respect to individual health benefit plans offered  
13 through the Exchange, in addition to the triggering events listed  
14 in this paragraph, any other events listed in Section 155.420(d) of  
15 Title 45 of the Code of Federal Regulations.

16 (2) With respect to individual health benefit plans offered  
17 outside the Exchange, an individual shall have 60 days from the  
18 date of a triggering event identified in paragraph (1) to apply for  
19 coverage from a health care service plan subject to this section.  
20 With respect to individual health benefit plans offered through the  
21 Exchange, an individual shall have 60 days from the date of a  
22 triggering event identified in paragraph (1) to select a plan offered  
23 through the Exchange, unless a longer period is provided in Part  
24 155 (commencing with Section 155.10) of Subchapter B of Subtitle  
25 A of Title 45 of the Code of Federal Regulations.

26 (e) With respect to individual health benefit plans offered  
27 through the Exchange, the effective date of coverage required  
28 pursuant to this section shall be consistent with the dates specified  
29 in Section 155.410 or 155.420 of Title 45 of the Code of Federal  
30 Regulations, as applicable. A dependent who is a registered  
31 domestic partner pursuant to Section 297 of the Family Code shall  
32 have the same effective date of coverage as a spouse.

33 (f) With respect to an individual health benefit plan offered  
34 outside the Exchange, the following provisions shall apply:

35 (1) After an individual submits a completed application form  
36 for a plan, the insurer shall, within 30 days, notify the individual  
37 of the individual's actual premium charges for that plan established  
38 in accordance with Section 10965.9. The individual shall have 30  
39 days in which to exercise the right to buy coverage at the quoted  
40 premium charges.

(2) With respect to an individual health benefit plan for which an individual applies during the initial open enrollment period described in subdivision (c), when the policyholder submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, by December 15, 2013, coverage under the individual health benefit plan shall become effective no later than January 1, 2014. When that payment is delivered or postmarked within the first 15 days of any subsequent month, coverage shall become effective no later than the first day of the following month. When that payment is delivered or postmarked between December 16, 2013, and December 31, 2013, inclusive, or after the 15th day of any subsequent month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(3) With respect to an individual health benefit plan for which an individual applies during the annual open enrollment period described in subdivision (c), when the individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs later, by December 15, coverage shall become effective as of the following January 1. When that payment is delivered or postmarked within the first 15 days of any subsequent month, coverage shall become effective no later than the first day of the following month. When that payment is delivered or postmarked between December 16 and December 31, inclusive, or after the 15th day of any subsequent month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(4) With respect to an individual health benefit plan for which an individual applies during a special enrollment period described in subdivision (d), the following provisions shall apply:

(A) When the individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage under the plan shall become effective no later than the first day of the following month. When the premium payment is neither delivered nor postmarked until after the 15th day of the month, coverage shall become effective no later than

1 the first day of the second month following delivery or postmark  
2 of the payment.

3 (B) Notwithstanding subparagraph (A), in the case of a birth,  
4 adoption, or placement for adoption, the coverage shall be effective  
5 on the date of birth, adoption, or placement for adoption.

6 (C) Notwithstanding subparagraph (A), in the case of marriage  
7 or becoming a registered domestic partner or in the case where a  
8 qualified individual loses minimum essential coverage, the  
9 coverage effective date shall be the first day of the month following  
10 the date the insurer receives the request for special enrollment.

11 (g) (1) A health insurer shall not establish rules for eligibility,  
12 including continued eligibility, of any individual to enroll under  
13 the terms of an individual health benefit plan based on any of the  
14 following factors:

15 (A) Health status.

16 (B) Medical condition, including physical and mental illnesses.

17 (C) Claims experience.

18 (D) Receipt of health care.

19 (E) Medical history.

20 (F) Genetic information.

21 (G) Evidence of insurability, including conditions arising out  
22 of acts of domestic violence.

23 (H) Disability.

24 (I) Any other health status-related factor as determined by any  
25 federal regulations, rules, or guidance issued pursuant to Section  
26 2705 of the federal Public Health Service Act.

27 (2) Notwithstanding subdivision (c) of Section 10291.5, a health  
28 insurer shall not require an individual applicant or his or her  
29 dependent to fill out a health assessment or medical questionnaire  
30 prior to enrollment under an individual health benefit plan. A health  
31 insurer shall not acquire or request information that relates to a  
32 health status-related factor from the applicant or his or her  
33 dependent or any other source prior to enrollment of the individual.

34 (h) (1) A health insurer shall consider as a single risk pool for  
35 rating purposes in the individual market the claims experience of  
36 all insureds *and enrollees* in all nongrandfathered individual health  
37 benefit plans offered by that insurer in this state ~~and all enrollees~~  
38 ~~in all nongrandfathered individual health benefit plans, as defined~~  
39 ~~in Section 1399.845 of the Health and Safety Code, offered in this~~  
40 ~~state by a health care service plan licensed under Chapter 2.2~~

1 ~~(commencing with Section 1340) of Division 2 of the Health and~~  
2 ~~Safety Code that is a corporate affiliate, subsidiary, or parent of~~  
3 ~~the insurer, state, whether offered as health care service plan~~  
4 ~~contracts or individual health insurance policies, including those~~  
5 insureds and enrollees who enroll in individual coverage through  
6 the Exchange and insureds and enrollees who enroll in individual  
7 coverage outside the Exchange. Student health insurance coverage,  
8 as such coverage is defined in Section 147.145(a) of Title 45 of  
9 the Code of Federal Regulations, shall not be included in a health  
10 insurer's single risk pool for individual coverage.

11 (2) Each calendar year, a health insurer shall establish an index  
12 rate for the individual market in the state based on the total  
13 combined claims costs for providing essential health benefits, as  
14 defined pursuant to Section 1302 of PPACA, within the single risk  
15 pool required under paragraph (1). The index rate shall be adjusted  
16 on a marketwide basis based on the total expected marketwide  
17 payments and charges under the risk adjustment and reinsurance  
18 programs established for the state pursuant to Sections 1343 and  
19 1341 of PPACA and Exchange user fees, as described in  
20 subdivision (d) of Section 156.80 of Title 45 of the Code of Federal  
21 Regulations. The premium rate for all of the health benefit plans  
22 in the individual market within the single risk pool required under  
23 paragraph (1) shall use the applicable index rate, as adjusted for  
24 ~~total expected marketwide payments and charges under the risk~~  
25 ~~adjustment and reinsurance programs established for the state~~  
26 ~~pursuant to Sections 1343 and 1341 of PPACA, marketwide~~  
27 *adjusted index rate*, subject only to the adjustments permitted  
28 under paragraph (3).

29 (3) A health insurer may vary premium rates for a particular  
30 health benefit plan from its index rate based only on the following  
31 actuarially justified plan-specific factors:

32 (A) The actuarial value and cost-sharing design of the health  
33 benefit plan.

34 (B) The health benefit plan's provider network, delivery system  
35 characteristics, and utilization management practices.

36 (C) The benefits provided under the health benefit plan that are  
37 in addition to the essential health benefits, as defined pursuant to  
38 Section 1302 of PPACA and Section 10112.27. These additional  
39 benefits shall be pooled with similar benefits within the single risk  
40 pool required under paragraph (1) and the claims experience from

1 those benefits shall be utilized to determine rate variations for  
2 plans that offer those benefits in addition to essential health  
3 benefits.

4 (D) With respect to catastrophic plans, as described in subsection  
5 (e) of Section 1302 of PPACA, the expected impact of the specific  
6 eligibility categories for those plans.

7 (E) Administrative costs, excluding any user fees required by  
8 the Exchange.

9 (i) This section shall only apply with respect to individual health  
10 benefit plans for policy years on or after January 1, 2014.

11 (j) This section shall not apply to a grandfathered health plan.

12 (k) If Section 5000A of the Internal Revenue Code, as added  
13 by Section 1501 of PPACA, is repealed or amended to no longer  
14 apply to the individual market, as defined in Section 2791 of the  
15 federal Public Health Service Act (42 U.S.C. Sec. 300gg-91),  
16 subdivisions (a), (b), and (g) shall become inoperative 12 months  
17 after the date of that repeal or amendment and individual health  
18 care benefit plans shall thereafter be subject to Sections 10901.2,  
19 10951, and 10953.

20 SEC. 27. No reimbursement is required by this act pursuant to  
21 Section 6 of Article XIII B of the California Constitution because  
22 the only costs that may be incurred by a local agency or school  
23 district will be incurred because this act creates a new crime or  
24 infraction, eliminates a crime or infraction, or changes the penalty  
25 for a crime or infraction, within the meaning of Section 17556 of  
26 the Government Code, or changes the definition of a crime within  
27 the meaning of Section 6 of Article XIII B of the California  
28 Constitution.